PATIENT NAME: _____

Playful Learning Pediatric Therapy LLC

12812 Old Glenn Highway Suite A-5
Eagle River, AK 99577
Phone: (907) 317-5895
Fax: (866) 628-8601

## Patient Intake/ Billing Information

**Last Name:**_____ **First Name:**_____ **Middle Initial:**_____

**Sex:**_____ **Patient DOB:**_____/_____/_____

**Parent or Guardian Name:**_____

**Address of child:**_____

**City:**_____ **State:**_____ **Zip:**_____ **Phone:**_____

**Mailing Address:**_____

**City:**_____ **State:**_____ **Zip:**_____

**Email:**_____

**Do you text?** _____ **Text number, if different than above:**_____.

**Responsible billing Party:**_____

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**Primary Insurance:**_____ **Insurance holders name:**_____

**Insured (i.e. parents) DOB:**_____

**Insurance identification number:** _____

**Secondary Insurance:** _____ **Insurance holder name:**_____

**Insured (i.e. parents) DOB:**_____

**Insurance identification number:** _____

**Emergency Contact:**_____ **Phone:**_____

**PATIENT NAME:** _____

## Release, Assignment and Statement of Responsibility

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to the provider(s). I understand that I may revoke consent at anytime in writing to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment.

## Consent to Treatment

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If the patient is a minor by signing I give consent for examination, tests and procedures for the above minor patient.

_____

**Signature** of Patient or Personal Representative: **Date:**
(Or Witness if signature is by mark)

**Printed Name of Personal Representative** or Witness Description of Personal Representative's Authority:

# Release of Liability

I as the undersigned acting as legal guardian and or legal power of attorney, give my informed consent for child:_____, to participate in any Occupational Therapy activity that is conducted in any location, this includes transportation to and from the location, on-site and community based therapeutic activities. These activities may include but are not limited to sports, water, boats, bicycles, swings, playgrounds, climbing walls, snow, ice, all wheeled recreational items, balls, ropes and jumping from various heights, trees, and interaction with other children or persons. I am aware that there are inherent risks in participating in activities that may challenge my child and I accept and am aware of these. In the event of any physical or mental injuries sustained in any activities facilitated by Playful Learning Pediatric Therapy, LLC its business associates in contract, all employees, managers and members of Playful Learning Pediatric Therapy, LLC are released from any and all liability.

## This release of liability is perpetual during the treatment time of the above participating person- beginning date of signature below.

**Child name:** **DOB:**_____

**Signature** of Patient or Personal Representative: **Date:**
(Or Witness if signature is by mark)

PATIENT NAME: _____

| **Printed Name of Personal Representative** or Witness Description of Personal Representative's Authority: |
|---|
| |


**Mailing Address:**
**12110 Business Blvd Ste A06-413**
**Eagle River, AK 99577**
**Phone: (907) 317-9349**
**Fax: (866) 628-8601**


# Notice of Privacy Practices & Your Rights

We are required by federal and state laws to maintain the privacy of your/ your child's 'Protected Health Information', PHI. Your signature below indicates you have received a copy of the 'Notice of Privacy Practices and Your Rights', which describes how health care information about you or your child may be collected, used and disclosed for purposes of treatment or payment or for other specified purposes that are permitted and required by law. This notice also details how you may access this information.

If you have any questions regarding this notice, please call us at (907) 317-9349

| | |
|---|---|
| **Child name:** | **DOB:** |
| **Signature/Title** of Patient or Personal Representative:<br>(Or Witness if signature is by mark) | **Date:** |
| **Printed Name of Personal Representative** or Witness Description of Personal Representative's Authority: | |
| **Witness signature/Title:** | **Date:** |

**PATIENT NAME:** _____

Playful Learning Pediatric Therapy LLC
12812 Old Glenn Highway Suite A-5
Eagle River, AK 99577
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# PATIENT AGREEMENT

Playful Learning Pediatric Therapy, LLC offers occupational therapy services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your therapy needs. We work with your primary care practitioner to coordinate your care.

Following your initial assessment visit(s), we develop a specific plan of care for review and approval by your referring provider. Once your referring provider signs your Treatment Plan, we can begin working with you to improve your health condition. We are pleased to serve your occupational therapy needs and encourage your feedback to alert us to anything we can do to provide you the highest quality of care.

We require certain information from each patient in order to begin your care. The attached forms need to be completed in order for us to get you started as our patient. Please do your best to complete all the information. If certain information does not apply to you, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payer has different guidelines for allowing coverage of occupational therapy services. If your healthcare insurance payer does not cover occupational therapy services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

**ALASKA MEDICAID RECIPIENTS:**

Alaska Medicaid requires that a physician, physician assistant or advanced nurse practitioner refer you to our practice before we can perform an initial assessment on you. After we have completed your initial assessment, we develop an individualized Treatment Plan to meet your specific therapy goals.

Your primary care practitioner will need to review & approve your Treatment Plan, and then return it to our practice before we can begin your treatment. Please understand that we cannot schedule your therapy appointments until after we have received your approved Treatment Plan.

## NO SHOW POLICY/ATTENDANCE POLICY

If you cannot make it to a scheduled appointment, please contact our office at least **12 hours** in advance. We will remove the patient from the schedule after 3 no-shows or 3 last minute cancelations (within 8 hours). Attendance is imperative in order for our therapists to make progress on the patient's plan of care. Please ensure 80% attendance for your appointments at all times. After an initial warning regarding attendance, we will remove the patient from their time slot.

**PATIENT NAME:** _____

## WAIT LIST FOR SERVICES

If you would like to reschedule an appointment for a day or time that is not available, please let us know and we will place you on our waiting list. If another patient cancels their appointment, we will contact patients on the waiting list on a first come, first call basis.

## MEDICAID & PRIVATE INSURANCE
## CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICE

Additionally, Medicare and private healthcare insurance payers have deductible and co-payments for occupational therapy services that are the responsibility of the patient.

## PATIENT DISCOUNTS FOR IMMEDIATE PAYMENT

If you would like to pay for your services at the time of your visit, we can offer you a 10% discount.

## COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

## FINANCIAL AGREEMENT

New patients approved for occupational therapy services are responsible for any and all charges not paid for by healthcare insurance payers. By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Playful Learning Pediatric Therapy, LLC for the services we provide to you, our valued customer. We accept cash, personal checks, and money orders. We also are willing to make reasonable payment arrangements to keep your account current.

## PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Playful Learning Pediatric Therapy, LLC to provide me occupational therapy services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

| |
|---|
| **Signature** of Patient or Personal Representative: Date:<br>(Or Witness if signature is by mark) |
| **Printed Name of Personal Representative** or Witness Description of Personal Representative's Authority: |

**PATIENT NAME:** _____


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# RELEASE OF PATIENT INFORMATION AUTHORIZATION FORM

| PATIENT NAME: | DATE OF BIRTH: |
|---|---|
| PHYSICIAN/PEDIATRICIAN NAME: | CONTACT NUMBER: |

| PEOPLE & ENTITIES I AUTHORIZE TO RECEIVE MY PROTECTED HEALTH INFORMATION | |
|---|---|
| **NAME OF ENTITY** | **CONTACT INFORMATION** |
| | |
| | |
| | |

**Please list medical practitioner(s), spouse, caregiver(s), guardian(s), etc. you are authorizing to receive PHI.**

**The purpose of this release of protected health information authorization:**

I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section at the bottom of this form, or by notifying Playful Learning Pediatric Therapy, LLC in writing, but if I do, it will not affect actions taken on this authorization before my revocation was received. I understand that Playful Learning Pediatric Therapy, LLC will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

_____I hereby give permission to Playful Learning Pediatric Therapy, LLC to photograph, video or audio record therapy sessions. These photos, videos or audio recordings can be used for education, marketing, or any other general purpose.

| This authorization expires on the following date or event: |
|---|
| **Signature** of Patient or Personal Representative: Date<br>(Or Witness if signature is by mark) |
| **Printed Name of Personal Representative** or Witness Description of Personal Representative's Authority: |

**PATIENT NAME:** _____

NOTE: This authorization was revoked on: _____ (see attached revocation). Complete when/if revoked.
Date

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL