PATIENT NAME: _____

Playful Learning Pediatric Therapy LLC

12812 Old Glenn Highway
Suite A-5
Eagle River, AK 99577
Phone: (907) 317-9349
Fax: (866) 628-8601

1901 Hemmer Rd
Suite 109
Palmer, AK 99645
Phone: (907) 795-8115
Fax: (866) 628-8601

613 S Knik Goose Bay Rd
Suite E
Wasilla, AK 99654
Phone: (907) 317-5895
Fax: (866) 628-8601

PATIENT INTAKE/BILLING INFORMATION

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

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

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:** _____

Emergency Contact:_____**Phone:**_____

Allergies?_____ **if yes, please specify:**_____

Responsible billing party (Parent/Guardian):_____

INSURANCE INFORMATION

Primary Insurance:_____**Insurance (i.e. parents) DOB:**_____

Insurance holders name:_____

Insurance ID #: _____ **Group #:**_____

Secondary Insurance:_____**Insurance (i.e. parents) DOB:**_____

Insurance holders name:_____

Insurance ID #: _____ **Group #:**_____

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/ Physical Therapy/ Speech 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)

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

PATIENT NAME: _____

Playful Learning Pediatric Therapy LLC

Mailing Address:
12110 Business Blvd Ste A06-413
Eagle River, AK 99577

NOTICE OF PRIVACY & 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 contact the clinic your child is scheduled at:

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Phone: (907) 795-8115

613 S Knik Goose Bay Rd
Suite E
Wasilla, AK 99654
Phone: (907) 317-5895

Child name: _____ **DOB:** _____
Signature/Title of Patient or Personal Representative: (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: _____

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PATIENT AGREEMENT

Playful Learning Pediatric Therapy, LLC offers occupational therapy/ physical therapy/ speech 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.

CODE OF CONDUCT

Our code of conduct serves as a guiding framework for families to ensure a supportive and respectful environment within our clinic setting. We request children to be closely supervised prior to and following all appointments within the waiting room setting to ensure their safety and prevent disruptions. Considering the medically fragile community we serve please notify the clinic via phone or text if your child is sick or has a fever prior to their appointment so that their appointment may be rescheduled. Our facility prohibits the presence of strong odors such as cigarette smoke, marijuana, and other synthetic fragrances. Families are encouraged to communicate politely and openly with their child's provider. It is essential for families to actively participate in their child's care, follow prescribed home plans, and collaborate with the child's provider to promote the best possible success for the patient. It is our expectation that all Playful Learning staff be treated with courtesy and kindness. Additionally, demonstrating empathy and understanding towards fellow families and patients fosters a harmonious atmosphere within the clinic and waiting room setting. This code of conduct aims to create a partnership between families and Playful Learning, fostering a compassionate team approach to patient care.

Parent/Guardian Initials: _____

SCHEDULING APPOINTMENTS

All insurance companies require that a physician, physician assistant, or advanced nurse practitioner review, sign, and return to us your treatment plan after initial evaluation. Please understand we are unable to schedule our therapy appointment until after we have received your approved treatment place from your referring or primary care provider. We may ask for your assistance to contact the provider in the event we are unable to make contact with them.

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/ physical therapy/ speech therapy services. If your healthcare insurance payer does not cover occupational therapy/ physical therapy/ speech therapy services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

Parent/Guardian Initials: _____

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.

Parent/Guardian Initials: _____

PATIENT NAME: _____

NO SHOW POLICY/ ATTENDANCE POLICY

It is imperative to patient continuity of care that our patients are able to make it to their scheduled appointments. If you cannot make it to a scheduled appointment, please contact our office at least 12 hours in advance. If we are contacted under 12 hours for a patient's scheduled appointment, the guardian will be required to reschedule the patient or charged a $50 fee for the last-minute cancelation. We will remove patients from the schedule after 3 no-shows or 3 last minute cancelations. Last minute cancels defined as notice less than 12 hours. We will remove patients who fail to reschedule after 3 last minute cancellations or do not pay the fees owed after 3 months. Attendance is imperative in order for PLPT to help your child make progress on their goals. Please ensure 80% attendance for your appointments at all time. When a patient is consistently below 80% attendance they will be removed from the schedule. After an initial warning regarding attendance, we will remove the patient from their time spot. If PLPT cancels your session, you will not be charged a fee and it will not count against your attendance.

Parent/Guardian Initials: _____

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

Medicaid and private healthcare insurance payers have deductible, coinsurance and/or co-payments for occupational therapy, physical therapy, and speech therapy services that are the responsibility of the patient.

Parent/Guardian Initials: _____

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.

Parent/Guardian Initials: _____

FINANCIAL AGREEMENT

New patients approved for occupational therapy, physical therapy, and/or speech 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 are also willing to make reasonable payment arrangements to keep your account current.

Parent/Guardian Initials: _____

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/ physical therapy/ speech 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: (Or Witness if signature is by mark)
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:

PATIENT NAME: _____

TELEHEALTH POLICY

Playful Learning may utilize telehealth (also known as telemedicine or telecounseling) to provide services to patients. Prior to utilizing telehealth, Playful Learning will review the service and its limitations with patients and ensure that they have read and acknowledged these limitations in the Electronic Communication Consent Form attached hereto as Appendix A. In addition, Playful Learning will review the following points with the patient at some point before initiating telehealth treatment:

1. Telehealth may not be covered by all insurance companies or other payers. If telehealth is not covered, the options for payment and charges for telehealth sessions should be reviewed with the patient.
2. Telehealth services may not be 100% secure, and are subject to the privacy and security policies and procedures of the technology provider. Patients should review the privacy and security policies of their preferred technology provider if there are any concerns regarding the confidentiality of telehealth services.
3. Telehealth services may not be able to include the full range of services available for an in-office visit. In addition, we can only provide guidance on the activities and topics we can view during a telehealth session. We are not responsible for anything that occurs during the session that is outside of our control.

At the beginning of each telehealth session, Playful Learning should review the following points with the patient:

1. If, at any time, the provider feels that the connections are not adequate, or the patient is not cooperating (i.e. patient is not willing to sit in front of camera, patient is not willing or able to sit in a private area, etc.), the provider may terminate the consult at any time.
2. If a telehealth consult is terminated as a result of inadequate technology or videoconferencing connection, the provider will attempt to reconnect at least one time, so long as there is time remaining in the scheduled session. The provider should obtain a phone number for the current location of the patient, in the event that reconnection is not possible, to allow for rescheduling.
3. If others are present on the patient side, the patient should inform Playful Learning so the provider can be aware and address such persons as appropriate.
4. Telehealth is not to be used for emergency situations. If a patient has an emergency, they should contact 911.

At the end of each telehealth session, the session should be documented in the same manner as any other session, except that the provider should be sure to note that it was conducted via telehealth. The Provider should also note the method of technology used (Skype, FaceTime, etc.) and any deficiencies in the service that may affect care (for example, if you are unable to see the patient due to a bad connection and are relying on audio only).

Patient Acknowledgement of Electronic Communications

The patient, or their representative, should be provided with a copy of this policy and should sign an acknowledgement in the form attached here to as Appendix A.

APPENDIX A: TELEHEALTH CONSENT FORM

Telehealth Services

Telehealth services are provided for the convenience of our patients. They are not required and will only be conducted with the consent of the patient. Telehealth services are subject to the following procedures and understandings:

- Telehealth services are not the same as an in-person visit, as you will not be in the same room as your provider. If your provider determines that telehealth is not adequate for a particular issue, the provider may choose to terminate the session.
- Telehealth services must be scheduled in advance at a designated time agreed upon by both the patient and provider.
- Telehealth services provided via computer should be accessed through a safe and secure connection. Be sure to use a computer that is in a confidential or private area and always fully exit all online counseling sessions when they are complete.
- Telehealth services may also include online functionality, such as posting of notes or chat logs during the session. This information may be printed by your provider, and if so, it will be treated as confidential.

- If telehealth services cannot be conducted due to technical difficulties, you should immediately contact your provider to schedule a new session.
- Telehealth services are not appropriate for all situations. If you are experiencing a crisis situation or emergency, you should contact 911 or go to the nearest emergency room.
- Some videoconferencing services may retain certain personal information for its users. This could include user contacts and addresses, and other personal information you provide to the service. You should review the privacy policy for the internet service provider if you have any questions about the confidentiality of such information.
- ELECTRONIC COMMUNICATIONS CAN BE MISDIRECTED TO OR INTERCEPTED AND DISCLOSED BY UNINTENDED THIRD PARTIES AND THUS MAY NOT BE A CONFIDENTIAL MEDIUM OF COMMUNICATION. PATIENTS WHO HAVE CONCERNS SHOULD CONSIDER USING ANOTHER MODE OF COMMUNICATION. PLAYFUL LEARNING DOES NOT WARRANT THE CONFIDENTIALITY AND SECURITY OF THIS FORM OF COMMUNICATION. PATIENTS ARE RESPONSIBLE FOR MAINTAINING THE CONFIDENTIALITY AND SECURITY OF THEIR OWN COMPUTERS, PHONES AND OTHER ELECTRONIC DEVICES.

PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS

Telehealth Consent

Using telehealth services is entirely voluntary. This office will provide referrals for treatment if you do not wish to utilize telehealth services.

Playful Learning is not liable for any claims and/or damages arising from following:

i. Interruption in the ability to conduct telehealth services due to technical difficulties, technical maintenance, or system failure.
ii. Access by friends, family members or other third parties who may enter the room on the patient side during telehealth sessions.
iii. Breaches of privacy and security due to the fault of the third-party videoconferencing provider (such as Zoom, FaceTime, Skype, Webex, etc.).
iv. Actions or activities that take place during the telehealth session that are not at the direction of the provider.

I have received a copy of the Telehealth Policy and do wish to use telehealth services. I have read this document carefully and understand the risks and benefits of telehealth services and have had my questions regarding the services explained. I hereby consent to participate in telehealth services under the terms described herein.

By signing below, you acknowledge that you have read and fully understand the Playful Learning Telehealth Policy. In addition, you agree to adhere to the policies set forth above, as well as any other instructions or guidelines that Playful Learning may impose for using electronic communications.

Signature of Patient or Personal Representative: (Or Witness if signature is by mark)	Date:
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:	

To **DECLINE** telehealth consent please sign below:

Signature of Patient or Personal Representative: (Or Witness if signature is by mark)	Date:
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:	

PATIENT NAME: _____

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Suite E
Wasilla, AK 99654
Phone: (907) 317-5895
Fax: (866) 628-8601

RELEASE OF PATIENT INFORMATION AUTHORIZATION FORM

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

PEOPLE & ENTITIES I AUTHORIZE TO EXCHANGE AND/OR 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
(Or Witness if signature is by mark)

_____ _____

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

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