On the Move Pediatric Therapy
(O) 859.224.0834
(F) 859.224.0882
www.onthemovepeds.com

NEW PATIENT INFORMATION

Today's Date: _____

Services Requested:

☐ Occupation Therapy ☐ Speech Language Therapy ☐ ABA Therapy (Applied Behavior Analysis)

Location Requested:

☐ Winchester
114 South Maple Street
Winchester, KY 40391

☐ Lexington
2647 Regency Road, Suite#107
Lexington, KY 40503

Child's Name _____

Gender: ☐ Male ☐ Female ☐ Non-binary

Child's Date of Birth _____ Child's Social Security # _____-____-_____

Child's Address _____

City/State/Zip _____ Home Phone _____

Mom:

Mom's Name _____ Mom's Date of Birth _____

Occupation _____ Employer _____

Wk phone _____ Cell Phone _____

Email Address _____

Dad:

Dad's Name _____ Dad's Date of Birth _____

Occupation _____ Employer _____

Wk phone _____ Cell Phone _____

Email Address _____

Who does the child live with (please include siblings if applicable)? _____

_____

How did you hear about us? ____Family ____Friend _____Doctor ____other: _____

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Informed Consent for Use of Email or Text Message

We appreciate the ease and efficiency of communicating with you through text and email. These modes of communicating may not always be technically secure. All efforts will be made to maintain confidentiality via email or text communication; however, that does not ensure confidentiality is maintained.
Concerning OTM email, all staff use a HIPAA-compliant email service; however, depending upon the email system you are using it may expose the communications to risk.

I, the undersigned, certify that I am requesting communication with OTM staff via electronic mail (email) and text message. Risk exists that any protected health information contained in such email or text message may be disclosed to, or intercepted by, unauthorized third parties. By signing this document, I acknowledge and understand this risk. I also acknowledge and understand that other, more secure methods of communication with OTM staff exist, including communication via telephone or non-electronic written communication.

_____ _____
Signature of Parent/ Legal Guardian Date

Physician:

Physician Information Referred By: _____

Address _____

City/State/Zip_____ Phone _____

Reason for Referral:

_____

_____

_____

Primary Care Physician (If different from referring physician): _____

Address _____

City/State/Zip_____Phone_____

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Insurance Information:

Primary Insurance_____

Claims Address_____

Customer Service Phone number _____ Fax _____

Insured's name_____ Social Security # _____

ID/Policy # _____ Group # _____

Secondary Insurance _____

Claims Address_____

Customer service Phone number_____ Fax _____

Insured's Name _____ Social Security # _____

ID/Policy # _____ Group # _____

Parent/Guardian Questionnaire Developmental History

Perinatal History – Please describe any complications before, during, and after birth:

_____

_____

_____

Approximate Age of Developmental Milestones:

Rolling: _____ Sitting: _____ Crawling: _____ Walking: _____

First Word: _____

Please discuss the current status of the following:

Mobility: _____

Speech: _____

Daily Skills (dressing, feeding, toileting, etc): _____

_____

School Performance: _____

Behavior: _____

Other: _____

Past Medical History:

Has your child ever received a diagnosis? (yes/No) If yes, who diagnosed child, what is the diagnosis, and when did child receive diagnosis? _____

_____

Previous hospitalizations/surgeries/illnesses – Please list type, date, and doctor

_____

_____

_____

_____

Previous or Present Therapies (if any):_____

_____

Current Medications: _____

_____

Allergies: _____

Photographic & Videotape Consent

Photography Consent:

_____I give permission for OTM to take photographs of my child. I understand that the photographs of my child will be included in OTM marketing materials. I understand that my child may be included in photographs with other children, and I give permission for any photo that includes my child to be shared through any marketing channel OTM chooses. I understand that this is a voluntary agreement and will not affect my child's therapy program and can be changed at any time.

_____ I do not give permission for OTM to take photographs of my child. I understand that this is a voluntary agreement and will not affect my child's therapy program and can be changed at any time.

Videotaping Consent:

_____ I give permission for OTM to videotape my child during sessions for the purposes of training OTM staff or his/her parents/caregivers only. I understand that the videotapes of my child will used for training purposes only. I understand that this is a voluntary agreement and will not affect my child's therapy program and can be changed at any time.

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_____ I do not give permission for OTM to videotape my child during treatment. I understand that this is a voluntary agreement, will not affect my child's therapy program and can be changed at any time.

Protection of confidentiality applies to photography or video taken by OTM to be used for the purposes of marketing material. No form of identification will ever be used. Your child's name will not be associated with the product information.
Lastly, data from your child's prescribed treatment program may be used in general research to benefit intervention awareness and will not have information to reveal the identity of your child.

I have read this consent and agree to its terms and conditions.

_____ _____
Signature of Parent/Guardian Date

Authorization to Pick Up

Parent/ Guardian has authorized the following people to pick up their child:

#	Name	Relationship to Child
1		
Primary Contact Number		Secondary Contact Number

#	Name	Relationship to Child
2		
Primary Contact Number		Secondary Contact Number

#	Name	Relationship to Child
3		
Primary Contact Number		Secondary Contact Number

- Additional names/contact information of persons authorized to pick up your child may be submitted with this New Patient Packet.

Any other transportation information you would like for us to be aware of:

_____ _____
Signature of Parent/ Guardian Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1) Uses and Disclosures: We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, other physical, occupational, and speech therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses: Our practice may use your PHI to send you an appointment reminder, to inform you of our health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law: The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight

agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others.
Your authorization is required before your PHI may be used of disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions: You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications: You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI: You have the right to request a copy of your medical record. You must make this request in writing, and we may charge a fee to cover the costs of copying and mailing.

Amendments: You have the right to request an amendment be made to you PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures: You have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints: If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy: We are required to comply with the federal health information privacy regulations by maintaining the privacy of you PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact: If you would like more information about our privacy practices or to file a complaint you may contact Shannon Lawson, Privacy Officer, at 859-224-0834 or shannon@otmpeds.com.

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I hereby acknowledge that I have been presented with a copy of On The Move Pediatric Therapy's Notice of Privacy Practices.

_____

Signature Date

_____

Relationship to Patient

(Notice of Privacy Practices revised 12/03/2014)

Authorization/Consent for Therapy Assessment / Treatment:

Authorization for Assessment: You hereby give consent for therapists of On The Move Pediatric Therapy to administer assessments and to use diagnostic tools in order to identify therapeutic needs.

Authorization for Treatment: You, the undersigned, hereby authorize On The Move Pediatric Therapy and/or any of their contractors, to render to patient physical therapy, occupational therapy, speech therapy, or other related services (collectively referred to as "Therapy Services") that we and/or your child's physician(s) determine to be necessary and advisable for your child. You agree to cooperate with all of our reasonable requests in connection with our rendering of Therapy Services.

Assignment of Benefits: You hereby assign and transfer to us the right to all third-party payments (including First Steps, Homeplace Support Services, or private insurance benefits) to which you may be or become entitled to for Therapy Services rendered by us. You hereby authorize us to apply and file for all such benefit payments on behalf of your child and direct that such payments be made directly to us. Any insurance benefit payments received by you for services we rendered shall be paid to us.

Payment Responsibility: You shall be financially responsible for any private pay accounts or for any required co-pays, co-insurance, or deductibles with insurance coverage, except in the event of covered services provided through First Steps, or Homeplace Support Services. You agree to execute any and all documents and perform any acts that we may reasonably request to ensure that all third-party benefits for Therapy Services are paid to us.

Accuracy of Information: You hereby certify that all information provided to us by you is true and accurate in all respects.

Notice of Privacy Practices: We refer you to our Notice of Privacy Practices for a detailed description of our privacy practices related to the Therapy Services. This Notice describes the permitted disclosures we may make under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

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Release of Information: Because HIPAA does not cover every situation in which we may be asked to provide information (which may include medical records) on your child, you hereby authorize us to disclose and release information to and receive information from the following agencies that have a legitimate interest in the provision of therapy services for your child.

(1) Private insurance as it pertains to claim reimbursement for therapy services.

(2) First Steps, or Homeplace Support Services, as applicable.

(3) Support staff may also view confidential information in the context of their work activities such as peer reviews but are required to keep such information private and confidential as a term of their employment.

(4) While not releasing a formal record, visitors to our center are likely to observe or take note of your child. These visitors may include but are not limited to: students, interns, parents, observers, tour participants, and contractors.

_____ _____
Signature of Client or Parent or Legal Guardian Date

_____ _____
Print Name Relationship

On The Move Financial Policy

1. It is the family's responsibility to make sure that insurance information provided is correct and current. Failure to provide such information will result in patient financial responsibility for all denied services.

2. All co-payments and coinsurance are due at the time of service.

3. It is the family's responsibility to know their insurance coverage and if therapy is a covered benefit. Families are required to monitor how many visits are being used.

4. All visits are applied to your deductible. Any visits that are not covered by your insurance are the financial responsibility of the patient and must be paid within 30 days after your insurance has denied payment. All accounts that are 120 days past due will be sent to a collection agency and services may be put on hold until accounts are brought current.

5. Any patient that carries a balance equal to or greater than $500.00 will be placed on hold until a payment plan can be arranged.

6. Once you've exhausted all of your approved therapy visits, or insurance has denied services, you may choose to stop services or pay out of pocket.

7. If the patient receives therapy through another agency and visits are denied due to visit maximum reached (i.e. used by First Steps) or duplicate services, you will be responsible for payment of services provided.

8. Appointments are set to optimize patient progress. Tardiness may impact the length of therapy visits and a visit may be cancelled if a patient is more than 7 minutes late. If you will be late for your scheduled appointment, please call our office so that we can plan accordingly and/or reschedule your visit, if needed.

9. Families who exhibit a pattern of cancellations/no shows (less than 80% attendance) may be discharged due to poor attendance. Two consecutive no shows may result in the discontinuation of services. Any appointments cancelled should be rescheduled, as our schedule allows.

10. Any personal check returned to the office for insufficient funds will have a $15 service charge added and all subsequent visits will need to be paid with cash, credit card or certified funds.

11. Families are offered a receipt of payment at the time of services.

Speak with Shannon Lawson, On The Move Practice Manager, with any questions you have regarding billing, financial issues, etc. (# 859/ 224-0834 or shannon@otmpeds.com).

Parent / Guardian Date