



PURE PEDIATRIC THERAPY

Pediatric Occupational and Physical Therapy

Dear Parents,

Thank you for choosing Pure Pediatric Therapy for your child's therapeutic needs. After scheduling your initial evaluation, please fill out the attached forms and have them ready to bring in with you at the time of your initial evaluation.

Please complete and sign the following forms **prior** to your child's initial evaluation:

- Financial Responsibility Agreement
- Attendance/Cancellation Policy
- Authorization for release of information
- Acknowledgement of receipt of privacy practices

In addition, we have included a packet of information, for your knowledge regarding obtaining insurance coverage for services, verifying your specific benefits, and notice of privacy practices. These forms **do not** need to be completed or returned to our office.

We encourage you to visit our website for frequently asked questions, explanations of therapy services provided, and testimonials. If you have any additional questions, please do not hesitate to call our office (949) 916-1654.

Thank you,

Pure Pediatric Therapy



PURE PEDIATRIC THERAPY

Pediatric Occupational and Physical Therapy

Financial Responsibility Agreement

Pure Pediatric Therapy is committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policies. Please read through this notice and initial where applicable. If you have any additional questions, please contact your insurance company prior to arriving to your scheduled appointment. Please initial the statements and sign below indicating your understanding of the following:

_____ It is your responsibility to contact your insurance company prior to receiving services. As a courtesy to our clients, Pure Pediatric Therapy, Inc. will also call your insurance company to determine your therapy benefits and coverage. **Medical insurance companies may initially state that they cover therapy. However, this is not a guarantee and they may deny services at any time.** If this occurs, Pure Pediatric Therapy, Inc., will make up to **TWO** attempts to submit your child's claims to your insurance company. After two attempts, we will bill you for the services provided and you will be responsible for the balance of services received.

_____ It is your responsibility to notify Pure Pediatric Therapy, Inc. of any insurance policy or benefit changes with regards to your child's services.

_____ All parents are expected to contact their insurance company and verify benefits with regards to occupational and physical therapy services. Please ask specifically about any "exclusions" or "limitations" to therapy benefits. **This quote of benefits from your insurance company is not a guarantee of payment.**

_____ Deductibles and co-payments are due at the time therapy services are rendered.

_____ If your primary or secondary insurance company makes payment to you (personally) and not to our office, due to contractual obligations, you are responsible for the entire balance between the amount paid by your insurance and the total allowable amount billed, per date of service. This includes amounts applied to your individual or family deductible, and is due upon receipt.

_____ If payment is not made to your account within 60 days, your child's services will be placed on hold until the balance is paid in full.

I have read and understand the Financial Responsibility Agreement. I hereby accept all financial responsibility for the evaluation and treatment costs incurred by my child. In addition, I authorize the release of any medical or other information necessary to process claims on my behalf.

Printed Name

Parent/Guardian Signature

Date

I hereby authorize and give consent for the licensed therapists at Pure Pediatric Therapy, Inc. to provide Occupational and/or Physical therapy services, including evaluation and treatment, to my child. I understand that my child is under the care and supervision of my therapist.

Printed Name

Parent/Guardian Signature

Date



PURE PEDIATRIC THERAPY

Pediatric Occupational and Physical Therapy

Attendance/Cancellation Policy

Please review the following cancellation policy. We want to emphasize that this policy is in place to ensure quality and continuity of care for your child. When you neglect to attend your regularly scheduled appointment or do not provide 24-hour cancellation notice your child misses out on valuable and vital therapy. In addition, your child's pediatrician has referred your child to us for necessary treatment and our desire is to provide the best possible care.

Cancellations must be made at least 24 hours in advance in order to avoid any charge for a therapy sessions. If you need to cancel an appointment after hours, you must leave a message in the General Voicemail at (949) 916-1654. Your same-day cancel MUST be rescheduled within 72 hours and the appointment must be completed within 30-days. If not, you will be billed.

I understand and agree to the following: (please initial and sign at the bottom)

___ If you same day cancel or "no show" for your initial evaluation, you will be billed \$50.00.

___ If you "no show" or do not give at least 24 hours notice for your regularly scheduled therapy session or initial evaluation, you will be billed \$50.00 on your next statement. (A "no-show" is defined as a missed appointment without a call or email to inform our office) There will be NO exceptions.

___ After 3 "no shows", your child's referring physician will be notified and all future treatments will be cancelled.

___ If your child is sick or you need to cancel your appointment on the day of your scheduled appointment, you MUST call the office to reschedule this appointment within 72 hours to avoid any late cancellation charges. The missed appointment must be made up within 30-days. We understand that your schedule is limited with other activities, school, and therapies, however there will be no exceptions made for restrictions in schedules.

___ Due to the importance of your child's session, if you arrive greater than 15 minutes late for your scheduled appointment, your child may NOT be seen and this will be considered a cancellation, unless you call to notify us ahead of time.

___ In the event your therapist is sick or on vacation, you will be notified as far in advance as possible. If you would like to be seen by an alternate therapist in the meantime, please speak to the front desk to coordinate scheduling.

Thank you for your cooperation and understanding of our cancellation policy and for helping us achieve our goal of providing the most consistent and continuous care for your child.

I have read and understand the Pure Pediatric Therapy attendance/cancellation policy.

Parent Signature

Date



PURE PEDIATRIC THERAPY

Pediatric Occupational and Physical Therapy

Authorization for Release of Information

My child is a client of Pure Pediatric Therapy, Inc., and I authorize the release of information and relative documentation regarding my child's participation in therapy. I understand I will be informed of the content of any conversations and release of medical information that is exchanged.

Child's Name

Date of Birth

I authorize the release of this information to the following professionals:

Pediatrician/Physician: _____

Additional Professionals:

Parent/Caregiver Signature

Date

Therapist Name

Date



PURE PEDIATRIC THERAPY

Pediatric Occupational and Physical Therapy

Acknowledgement of Privacy Practices

Patient's Full Name: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand this information will be used to:

- (a) Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- (b) Obtain payment for services, and
- (c) Conduct normal health care operations.

I understand the acknowledgement of privacy practices and understand that Pure Pediatric Therapy, Inc., has the right to change it's policies and procedures, however acknowledge that Pure Pediatric Therapy, Inc., will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I understand that I may request a copy of Notice of Privacy Practices to provide further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, and healthcare operations, and otherwise allowed by law.

Signature of Parent or Guardian

Date