INTAKE INFORMATION

Please fill out all of provided fields below:

Child's Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **Zip:** _____ **Primary Phone:** _____

Diagnosis: _____

Family Email: _____

Mother: _____ **Work/Cell Phone :** _____

Father: _____ **Work/Cell Phone:** _____

Insurance Co.: _____ **Payer:** _____

Billing Address: (See back of Insurance Card Copy) _____

Insurance Phone #: _____

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

Insured Person: _____ **DOB:** _____

Employer: _____ **City:** _____

Physician/Service Providers

Pediatrician Or Family Doctor:
Name_____
Address_____
Phone_____

Orthopedist:
Name_____
Address_____
Phone_____

Neurologist:
Name_____
Address_____
Phone_____

Eye Doctor:
Name_____
Address_____
Phone_____

Ear Doctor:
Name_____
Address_____
Phone_____

CFC Coordinator:
Name_____
Address_____
Phone_____

Other:
Name_____
Address_____
Phone_____

I authorize Sovereign Pediatric Therapy to forward copies of my child's Therapy Progress Reports to the above doctors/CFC directors.

_____ _____

Parent's/Guardian's Signature **Date**

Parent Authorization Form

1. Emergency Release

I, _____, give my permission for Sovereign Pediatric Therapy to obtain emergency medical care for my child, in case of an emergency while my child is receiving treatment at Sovereign Pediatric Therapy. I hereby release and hold harmless Sovereign Pediatric Therapy from any responsibility for any emergency care sought per my permission via this Emergency Release.

Parent's/Guardian's Signature **Date**

Witness **Date**

Patient Information Consent Form

I have read and fully understand Sovereign Rehabilitation's Notice of Patient Information Practices. I understand that Sovereign Rehabilitation may use or disclose my child's personal health information for the purpose of carrying out treatment, obtaining payment, evaluation of the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my child's personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Sovereign Rehabilitation will consider request for restriction on a case-by-case basis, but does not have to agree with the request for restrictions.

I hereby consent to the use and disclosure of my child's personal health information for the purposes as noted in Sovereign Rehabilitation's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

Parent's/Guardian's Signature **Date**

Therapy Attendance

The goal of Sovereign Pediatric Therapy is to provide your child with the best possible therapy services and the best possible therapy outcomes. Frequent cancellations interfere with the effectiveness of therapy by delaying the accomplishment of therapy goals and extending the duration of therapy required. For these reasons, we ask that you **make a commitment to regular therapy attendance** by your child and avoid scheduling doctor and other types of appointments/activities at times that your child would normally be attending therapy.

Cancellations

Sovereign Pediatric Therapy reserves your scheduled therapy times exclusively for your child or child's group. Last minute cancellations preclude the use of those times for other children who may be waiting for evaluation and therapy times.

Sovereign Pediatric Therapy requires a minimum 24-hour notice for all cancellations. For planned vacations or other unavoidable activities which require a cancellation of therapy, **we request that you notify the front office as soon as you are aware of the need to cancel therapy,** but with a 24 hour minimum notice.

Sickness/Hospitalizations

Children should not be brought to therapy when they are sick. Children must be free from a fever, diarrhea and vomiting for at least 24 hours before coming to therapy. If your child has any of these conditions the day before a scheduled therapy appointment, you should cancel your child's appointment for the next day with enough time to allow a 24-hour notice of cancellation. If your child has been hospitalized 24 hours or longer for any reason (illness or surgery), a new prescription from the doctor is needed to reinitiate therapy. The easiest way to obtain the prescription is to request it from your physician upon discharge from the hospital. Normally, a child is not taken off of the schedule when hospitalized unless specifically requested by the parent or if the hospitalization will last more than two weeks. On the first visit to the Sovereign Pediatric Therapy after the hospitalization, please bring the prescription explaining what your child was hospitalized for.

Frequent Cancellations

A child who frequently misses their regularly scheduled appointments may be asked to attend on an on-call basis, move to another more convenient time, or discontinue services at the discretion of Sovereign Pediatric Therapy.

No shows

Any missed appointment without a cancellation call in advance will be charged a $50.00 No Show charge which **must be paid at or before the next scheduled visit**. Services can only be resumed after all No Show charges have been paid in full.

*Sovereign Pediatric Therapy does not follow the school calendar and is open on many school holidays**.** If you are unsure whether your child will have therapy on a school holiday, please call the day before to check in order to avoid a No Show charge.

I have read, understand, and agree to follow the above policies related to therapy attendance.

Parent's/Guardian's Signature **Date**

Financial Agreement

Sovereign Pediatric Therapy is committed to providing the highest quality of therapy to all of its clients. In order to do so, Sovereign Pediatric Therapy and its clients must understand the benefits provided to the client through their insurance provider, or clearly outline a fee structure for services that will be paid in full by the client directly.

Many insurance plans have deductibles, co-insurance, and co-pay amounts that are the client's responsibility; deductibles must be met before insurance will begin to cover the cost of therapy. These deductibles apply to ALL medical providers; they are not isolated to therapy.

Sovereign Pediatric Therapy does require prompt payment for services provided, and all accounts that have not received full payment towards the patient account balance within 60 days of the date of service will have the credit card on file charged accordingly. If an account, for any reason, goes beyond 60 days past due, and a payment plan has not been arranged, your account may be forwarded to a collections agency. In addition, any scheduled therapy sessions will be cancelled until the outstanding balance is paid in full.

Any verification of insurance benefits obtained by Sovereign Pediatric Therapy is for the convenience of the undersigned. This information is not a guarantee of benefits, and does not hold Sovereign Pediatric Therapy responsible for the collection of any insurance payments. If a claim issue arises, the parent may be asked to contact the insurance carrier for claim resolution. **Payment including deductibles, co-pays, coinsurance amounts, and self- pay charges are due at the time of service unless other arrangements are made per the agreement of Sovereign Pediatric Therapy.** If the center is forced to pursue legal means to collect money owed for services rendered, the person/s signing below will also be responsible for any costs incurred by Sovereign Pediatric Therapy in pursuit of collection, including court costs, costs of service, any and all attorney's fees, and any other expenses incurred for collection of said moneys owed.

> I recognize and accept full personal financial responsibility for all professional services rendered. My signature below reflects my understanding of the financial policy at Sovereign Pediatric Therapy and I adhere to this agreement. I assign benefits and authorize insurance payment directly to Sovereign Pediatric Therapy. I also authorize Sovereign Pediatric Therapy to release any information required to process any claims or insurance appeals.

Child's Name **Date**

Parent's/Guardian's Signature **Date**

Credit Card Policy

Effective January, 2012, all clients are required to keep a credit card on file with Sovereign Pediatric Therapy in order to receive services. Simply because there is a credit card on file does not mean that we will bill your card every month. If you wish to pay by check, cash or by another credit card for your monthly balance, that is acceptable. The credit card that is on file will be charged for all outstanding balances greater than 60 days past due if no payment arrangement has been made. It can also be used should a payment plan be arranged with our staff. Please *initial the choice* of how you would like your credit card used below:

_____ 1) Please charge my card for all patient balances in full that are past due greater than 60 days (a courtesy call will be done by our office staff to let you know a charge is being processed)

_____ 2) Please charge my card on or about the first of each month for all co-pays, co-insurances, or deductibles that have accrued for the previous month.

PATIENT NAME: _____

(Please enter all information listed in the box below):

Cardholders Name:
Card Type(circle one): VISA MASTERCARD DISCOVER
Card Number:
Expiration Date:
Security Code: N/A
Billing Zipcode:
Cardholder's phone #:
Cardholder's Signature

*I understand that by signing above, in the Cardholder's signature box, I am authorizing Sovereign Pediatric Therapy to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, deductibles, or self-pay charges. I understand that Sovereign Pediatric Therapy will mail me a printed statement as well as the receipt from my credit card as proof of payment.