Activekidz
& Adult Therapy

Name: _____ **DOB:** _____

Social Security Number: _____ **Phone:** _____

Address: _____

City, State, Zip Code: _____

Email Address: _____

Employer: _____ **Phone:** _____

Diagnosis (if known): _____

Primary Physician: _____

Group Name: _____ **Physician's Phone:** _____

Address: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Other doctors and specialists who provide care for you:

Name	Specialty	Phone Number

Patient Name: _____

Describe in your own words the nature of your concerns:

_____

_____

_____

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies: Yes No If yes, please describe: _____

_____

Patient Name: _____

PRIMARY INSURANCE:

Name of Insured_____

Birthdate_____ Social Security #: _____

Relationship to Patient_____

Insurance Company Name_____

Claims Address_____

City_____State_____Zip Code_____

Customer Service Telephone_____

Group Name_____ Policy Number_____

Group Number _____

ADDITIONAL INSURANCE:

Name of Insured_____

Birthdate_____ Social Security #: _____

Relationship to Patient_____

Insurance Company Name_____

Claims Address_____

City_____State_____Zip Code_____

Customer Service Telephone_____

Group Name_____ Policy Number_____

Group Number _____

Activekidz
& Adult Therapy

Clinic Address: _____

Clinic Telephone Number: 770-207-6390 Clinic Fax Number: 678-374-4855

Patient Name: _____

DOB: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:

I hereby request that payment of authorized health insurance plan and/or Medicaid benefits be made on my behalf to Activekidz of therapy services provided. I authorize Activekidz to release and/or receive information from/to my third party payer/insurer and/or to the Health Care Financing Administration and it's agents, if necessary, any medical needed to determine the benefits payable for related services. I understand I will be personally responsible for any amount denied, or any remaining amount owed for services partially covered by my third party payer/insurer. I also authorize Activekidz to release and/or receive information from/to schools, doctors including specialist/surgeons and DFCS.

I authorize the following individuals to have access to my health information:

_____

_____

Patient_____Date_____

FINANCIAL POLICY

Please initial beside each paragraph stating your understanding of each item

_____ If you have a deductible, we will ask that you make a down payment of $100 for the evaluation and $50 at each therapy appointment. As soon as we begin receiving claims back, we can give you a definite price for each visit and we ask that this be paid at the time of service.

_____ We verify your benefits with your insurance company prior to your first appointment with us. However, the benefits quoted to us are not a guarantee. Your insurance may pay differently than what is quoted. It is ultimately your responsibility to know how your insurance will cover you for your services with us.

_____ We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment or your estimated share be made upon receipt of your billing. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

_____ In the event that you run out of approved visits through your insurance company, you will be considered private pay until the next calendar year begins with your insurance company. In order to receive the private pay rate, you will be asked to pay at each visit.

_____ If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to us by forwarding the actual payment with explanation of benefits to our office, with endorsement made and reassigned to provider.

_____ I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

_____ Medical Records will not be released to any person or other medical facility if there is an unpaid balance on the account.

I have read the above information and understand my responsibility for the payment of my account.

Patient_____Date_____

ATTENDANCE POLICY

Activekidz is pleased that you have chosen us to provide you with your therapy needs. We provide services to many patients in the surrounding areas and unfortunately have to turn patients away due to our therapist's full schedules. You must be present for at least 75% of scheduled therapy sessions or services may be terminated. We request that you cancel your appointment with *all therapists* you are seeing 24 hours prior to your appointment in order for us to see another patient in need. We do understand that emergencies arise and we are more than willing to work with each case as it arises. If you cancel the day of your scheduled appointment you will be charged a $15 fee. If you are not present for a scheduled appointment, you will be charged a $25 fee. If your appointment can be rescheduled during the same week you will not be responsible for payment of any fees. If you have 3 no shows without prior notification then services will be terminated. All fees will be collected at the next scheduled appointment. We greatly appreciate your understanding in this matter.

Patient_____ Date_____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Activekidz, Inc., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Activekidz, Inc.
I understand that diagnosis or treatment of me by Activekidz, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice.

Activekidz, Inc. is not required to agree to the restrictions that I may request. However, if Activekidz, Inc. agrees to a restriction that I request, the restriction is binding on Activekidz, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that Activekidz, Inc. or Activekidz, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Activekidz, Inc.'s Notice of Privacy Practices prior to signing this document.

The Activekidz, Inc.'s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Activekidz, Inc.

The Notice of Privacy Practices for Activekidz, Inc is also provided in the Office Manager's office and will be on the Activekidz, Inc. website when developed.

The Notice of Privacy Practices also describes my rights and the duties of Activekidz, Inc. with respect to my protected health information.

Activekidz, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
I may obtain a revised notice of privacy practices by accessing the Activekidz, Inc.'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient_____Date_____

NOTICE: PATIENT PRIVACY

Date January 1, 2011

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

ACKNOWLEDGEMENT:

I acknowledge by signing below that I have received and read or had explained to me this Notice of Privacy Practices for Activekidz, Inc.

Patient's Name:_____

Date:_____

Tel: 770-207-6390 Fax: 678-374-4855

This is to certify that I, _____ DOB _____

has received prior therapy or an evaluation for _____ therapy at

_____ facility, but I wish to transfer services to Activekidz Therapy.

I no longer wish to receive services at the previous facility.

My last evaluation at the previous facility was _____.

My last visit (session) at that facility was _____.

If there is an open authorization in place at the previous facility, please end it so that I may begin services with Activekidz Therapy.

Thank you!

_____

Patient Signature

_____

Date