

Registration Information

Child's Full Name _____

Date of Birth ____/____/____

Primary Diagnosis _____

Additional Diagnoses _____

Parent's Information

Father's Name	Mother's Name
Home Phone	Home Phone
Work Phone	Work Phone
Cell Phone	Cell Phone
Father's DOB	Mother's DOB
Father's SS#	Mother's SS#
Father's E-mail	Mother's E-mail

Child's Address

Street Address _____

City _____ State _____ Zip _____

Insurance Information

Primary Insurance Co.	Secondary Insurance Co.
Insured's Name	Insured's Name
Policy Number	Policy Number
Group Number	Group Number
Claims Address	Claims Address
Phone	Phone
Employer's Name	Employer's Name
Employer's Address	Employer's Address

Medicaid # _____

Authorization for Release of Information

Patient: _____

Date of Birth: ____/____/____

I hereby authorize and request Special Needs Pediatric Therapy Services to release my child's treatment records and/or progress reports to the following persons/institutions:

Referring Physician

(Physician's first and last name)

(Street Address)

(Practice Name)

(City, State, Zip)

(Phone Number)

Babies Can't Wait (children under 3)

Specialist (ie...neurologist, orthopaedist)

(Service Coordinator)

(Name)

(County)

(Practice Name)

(Phone Number)

(Phone Number)

School-Based Physical Therapist

School-Based Occupational Therapist

(Name)

(Name)

(School Name/County)

(School Name/County)

(E-mail Address or Phone Number)

(E-mail Address or Phone Number)

I understand that evaluations/re-evaluations will be released to my referring physician, and to Babies Can't Wait if applicable, as they are performed, and that progress reports will be released twice per year unless otherwise requested.

Parent/Legal Guardian Signature _____ Date _____

I authorize the release of any information necessary to process insurance claims.

Parent/Legal Guardian Signature _____ Date _____

I hereby authorize my insurance carrier to issue payment of benefits directly to Denise M. Hoell, PT, d/b/a Special Needs Pediatric Therapy Services. I recognize that certain charges may not be covered by my medical insurance and that I am financially responsible for all charges incurred.

Parent/Legal Guardian Signature _____ Date _____

I further acknowledge that if I fail to disclose changes in insurance coverage in a timely manner, and the failure to disclose this information deems services not covered either with my primary insurance carrier, my secondary or tertiary insurance carrier, or with Medicaid, that I am financially responsible for all charges incurred.

Parent/Legal Guardian Signature _____ Date _____

The above authorizations shall be effective from January 1, 2009 (or from the date of the child's initial visit), until December 31, 2009

Special Needs

Pediatric Therapy Services

Notice of Privacy Practices

In 1996, the Federal Government established uniform privacy and security standards to protect patients' medical information. The standard is known as the Health Insurance Portability and Accountability Act (HIPAA).

The purpose of this notice is to ensure that you (the patient) or your designated representative is aware of your rights to ensure the privacy of your healthcare information. Special Needs Pediatric Physical Therapy retains the right to update this notice at any time. You will be notified of any changes and you will receive an updated copy from Special Needs Pediatric Physical Therapy upon your request.

1. Privacy of Patient Information

We have created a record of the services and treatment you receive in order to file claims with your insurance company and Medicaid, as well as maintain the highest quality care possible and maintain documentation regarding your status at the time of initial evaluation as well as across the span of your treatment. The privacy of your medical information is important to us and we are committed to protecting it. We are required by law to keep your medical information private and notify you of your legal rights and our privacy practices.

2. Use and Disclosure of Patient Information

Your medical information will be used for payment and operations to maintain the highest quality care possible. HIPAA allows disclosure of this information to your designated/authorized next of kin and other health care providers including physicians, insurance companies, state and federal entities as well as law enforcement agencies in the interest of public safety. You, the patient, however, reserve the right to request in writing restrictions on certain uses and disclosures.

3. Patient's Access to Medical Information

You have the right to see and obtain a copy of your medical records at any time. You may request changes in your health information and request the reason for any disclosures (not including treatment, payment and healthcare procedures). If Special Needs Pediatric Physical Therapy does not agree with your changes, you must be allowed to insert a statement of disagreement into the record. Special Needs Pediatric Physical Therapy is not required to agree to your requested restrictions. However, if we agree, the restriction is binding.

4. Confidentiality of Patient Information

Special Needs Pediatric Physical Therapy will attempt in all cases to preserve the confidentiality of all oral and written medical information. These include transmission of patient's records only to such payers as are HIPAA compliant, reasonable confirmation of the security of patient information prior to electronic and/or fax transmission of information necessary to complete billing, and law enforcement agencies necessary in the interest of public safety. Special Needs Pediatric Physical Therapy will not be held responsible in the event of natural disasters, or theft, or burglary of their physical and electronic property, having taken reasonable precaution.

5. How to File a Complaint

You may file a complaint if you feel that your privacy rights have been violated. Special Needs Pediatric Physical Therapy will not retaliate against you if you file a complaint. A complaint form is available upon request.

6. Special Needs Pediatric Physical Therapy Contact Information

You may contact Denise M. Hoell, PT, the security administrator of Special Needs Pediatric Physical Therapy, for more information of your privacy policies at the above address and telephone.

Parent/Legal Guardian Signature _____
Date _____