PATIENT INFORMATION

Please indicate which therapy you would like:

☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy

☐ Applied Behavioral Analysis

Patient's Name: ______________________________

Date of Birth: ______________ SS #: ______________

Address: ______________________________

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Home Phone: ______________________________

Email Address: ______________________________

Primary Care Physician / Pediatrician: ______________________________

Concern or Child's Diagnosis/Date of Onset: ______________________________

Referred By: ______________________________

PARENT / GUARDIAN INFORMATION

Parent's Name: ______________ SS #: ______________

Occupation: ______________ Employer: ______________

Spouse's Name: ______________ SS #: ______________

Mom's Cell Phone: ______________ Dad's Cell Phone: ______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

INSURANCE INFORMATION

******Please attach a copy of the front & back of patient's insurance cards******

(If the insurance information has been provided over the phone, please skip to the next section)

Primary Insurance: ______________________ ☐ HMO ☐ PPO

Insured Name: ______________________ ID # ______________________

Group # : ______________________ Phone # ______________________

Secondary Insurance: ______________________ ☐ HMO ☐ PPO

Insured Name: ______________________ ID # ______________________

Group # : ______________________ Phone # ______________________

Is your child currently receiving services by any other therapists? If YES, Please list below

YES / NO Occupational Therapy ______________________

YES / NO Physical Therapy ______________________

YES / NO Speech Therapy ______________________

YES / NO Other ______________________

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
I further realize that I am personally responsible for charges not covered by this insurance.
I also authorize the release of any medical or other information necessary to process this claim.

Parent / Guardian Signature: ______________________

Date: ______________________

PATIENT HISTORY FORM

- ☐ YES ☐ NO CANCER
- ☐ YES ☐ NO HEART PROBLEMS
- ☐ YES ☐ NO WEAKNESS OR PARALYSIS
- ☐ YES ☐ NO BROKEN BONES
- ☐ YES ☐ NO PROBLEMS WITH JOINTS
- ☐ YES ☐ NO SENSORY DIFFICULTIES
- ☐ YES ☐ NO VISUAL PROBLEMS
- ☐ YES ☐ NO ALLERGIES
- ☐ YES ☐ NO ACTIVITY RESTRICTIONS
- ☐ YES ☐ NO SEIZURE DISORDER

LIST OF CURRENT MEDICATIONS: ____________________

LIST ALL HOSPITALIZATIONS AND/OR SURGERIES: ____________________

PRENATAL AND BIRTH HISTORY: ____________________

PLEASE LIST / EXPLAIN ANY CONDITIONS THAT EXISTED BEFORE, DURING OR FOLLOWING BIRTH THAT REQUIRED INTERVENTION: ____________________

PLEASE LIST ANY OTHER HEALTH PROBLEMS OR CONCERNS: ____________________

PAYMENT POLICIES, GENERAL GUIDELINES, HIPPA NOTICE, CONSENT FOR TREATMENT

Dear Patient / Parent:

Thank you for choosing Great Strides Rehabilitation, Inc. to meet your therapy needs. Our staff is dedicated to serve you in the most efficient and effective manner possible. You can help us by following the guidelines below:

1. **Insurance-** It is suggested that you verify coverage for the services prescribed by your physician and make the proper arrangements for any non-covered services. In addition to our verification of our benefits, you can verify your own benefits by calling the number on the back of your insurance card.

It is important to note that we are considered an **"out of network provider" for many insurance companies. As a result, payment can differ from that of "in network providers". It is likely that you will have a co-insurance instead of a co-payment. Some or all of the charges incurred may need to be collected at the time of the visit.

PAYMENT FOR ALL SERVICES NOT COVERED BY INSURANCE ARE THE PATIENT'S RESPONSIBILITY. IF YOUR INSURANCE COMPANY LIMITS THE NUMBER OF VISITS YOU RECEIVE PLEASE TRACK THEM TO PREVENT EXCEEDING COVERED VISITS.

EFFECTIVE 01.01.08, A FILING FEE WILL BE CHARGED FOR CLAIMS WHICH HAVE BEEN BILLED AND DENIED BY INSURANCE.

IN SOME CASES PAYMENT WILL GO DIRECTLY TO YOU THE SUBSCRIBER. IN THIS CASE WE REQUIRE PAYMENT BE MADE TO US IMMEDIATELY WITH A COPY OF ALL EXPLANATIONS OF BENEFITS. FAILURE TO DO SO MAY RESULT IN THE FULL CHARGE BEING INVOICED TO YOU.

CHARGES NOT REIMBURSED BY YOUR INSURANCE COMPANY WITHIN 90 DAYS OF TREATMENT DATE WILL BE INVOICED TO YOU. SHOULD INSURANCE PAY AT A LATER DATE YOUR ACCOUNT WILL BE SETTLED ACCORDINGLY.

PAST DUE ACCOUNTS ARE SUBJECT TO LATE FEES AND OR ADDITIONAL COLLECTION FEES.

BILLING QUESTIONS SHOULD BE DIRECTED TO: PROMED CLAIMS SOLUTIONS, ATTN: CHARLOTTE LAVERGNE 904-879-4230

*****PLEASE INITIAL THAT YOU HAVE READ THE ABOVE STATEMENTS***** ________________

2. **Cancellation:** Please notify Great Strides Rehabilitation, 24 hours in advance, of any appointments you cannot keep. A reasonable and customary fee may be applied to appointments missed without sufficient prior notification. **You may reach your therapist at 886-3228.**

3. In consideration of other patients and staff, it is necessary that appointment times are adhered to and cancellations are avoided. **If you are going to be late for your scheduled appointment, please call and make sure your therapist will still be able to see you.** Your appointment may have to be rescheduled. At times, the therapist may be behind schedule. Please understand that this may be due to unforeseen circumstances and your patience is appreciated.

4. If you have 3 or more cancellations or no-shows in one quarter, remaining appointments may be taken off the schedule and your child will be subject to being discharged.

5. After each therapy session, please confirm you next appointment with your therapist.

6. The therapist will, whenever possible, maintain communication with your physician in order to discuss an appropriate plan of care and realistic expectations.

If there is anything we can do to make your therapy session better, please do not hesitate to bring it to our attention

I do hear by give consent for treatment services to be rendered to my child.

I have received or read the notice of information practices and I have been provided an opportunity to review it.

_______________________________________ _______________

Parent's signature (or legal guardian) Date

*Please make sure you initialed under the insurance section on page 1.

***** This agreement will remain in effect for the duration of you child's therapy with Great Strides Rehabilitation. *****