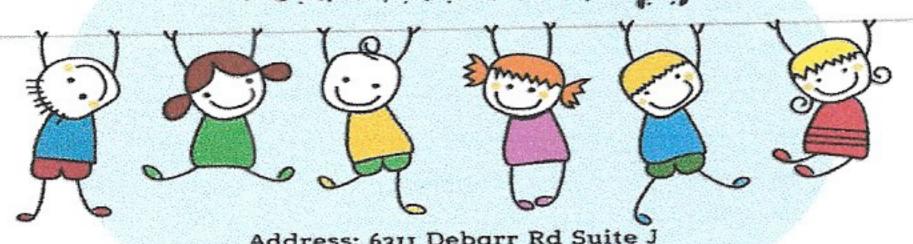
## KIDS ARE PEOPLE TOO!

What concerns bring you in today?
What activities is your child able to perform at home?
What are your biggest goals for physical therapy?
Has your child received any previous treatments? (OT, PT, ST etc.)
Were there any complications with the pregnancy or birth? (traumatic delivery, low birth weight, low Apgar score, time spent in the NICU, required oxygen, etc.)
Did you have, or are you currently having, any difficulties with nursing or feeding? Is your child a picky eater?
Is your child taking any medications?  If so, what are they?
Is there any medical information you would like to share? Is there any family medical history that we should be aware of?
What grade is your child in and what school does he/she attend?
Is there any additional information that you would like us to know?

## Kids Are People Too! LLC Pediatric Therapy



Address: 6311 Debarr Rd Suite J Phone: (907)231-6268 www.kidsarepeopletoopt.com

## Consent for Release of Information and Billing Child: \_\_\_\_\_ Address: Parent/Guardian: Phone: ( ) \_\_\_\_\_ Pediatrician: Diagnosis: Referral Source: Medicaid ID Insurance Provider: Address: Sponsor Name: SSN Number: <<<<<<<<<<<<<<<<<< I, \_\_\_\_\_\_\_\_ parent/guardian of \_\_\_\_\_\_ authorize the release of written and verbal information pertaining to my child's physical therapy and medical program To and FROM Karen Adams, MSPT and the following persons and agencies: 1. Insurance Company 2. Pediatrician 3. Infant Learning Program 4. Other Therapists (OT, SPT) 5. Other Medical Providers Date \_\_\_\_ Signature \_\_\_\_\_ I understand that my child's records may be reviewed by state representatives for the purpose of Medicaid/Medicare certification or by therapists or pediatricians for the purpose of professional peer review of licensing: Signature \_\_\_\_\_ Date \_\_\_\_ I authorize payment of insurance and Medicaid benefits directly to Karen Adams, MSPT: Date \_\_\_\_ Signature \_\_\_\_\_ I agree to pay my portion of the insurance deductible directly to Karen Adams, MSPT: Date \_\_\_\_\_ Signature \_\_\_\_\_ I have read the Notice of Privacy Practices and Your Rights:

Signature\_\_\_\_\_

Date

Kids Are People Too, LLC 6311 Debarr Rd – Suite J Anchorage, AK 99504

April 11, 2018

To All Our Families,

We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality of care for all our patients in a timely and respectful manner.

Due to some recent changes with private and state insurance companies it will now be required for all our families to be financially responsible for co-pays that have been designated by your individual insurance companies. Starting May 1, 2018, co-payments will be expected at the beginning of your child's session.

Your child's needs are our first priority. If this notice causes a financial hardship for any of our families, please speak with our office management to make arrangements for a payment plan.

Thank you for your continued patronage, as we aim to give you our best care!

Sincerely,

Kids Are People Too! LLC

PATIENT NAME	
CANTERNA LABORATE	Name and Day

## Kids Are People Too!

Kids Are People Too!. Pediatric Physical Therapy
2440 East Tuder Rd #338
Anchorage, Ak 99507
907-830-3592 OFFICE PHONE
866-408-0538 FAX NUMBER

### HOURS OF OPERATION MONDAY THROUGH THURSDAY: 9:00 AM - 5 00PM

### PATIENT AGREEMENT

Kids Are People Too!. offers pediatric physical therapy services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your therapy needs. We work with your primary care practitioner to coordinate your care.

Following your initial assessment visit(s), we develop a specific plan of care for review and approval by your referring provider. Once your referring provider signs your Treatment Plan, we can begin working with you to improve your health condition. We are pleased to serve your child's physical therapy needs and encourage your feedback to alert us to anything we can do to provide you the highest quality of care.

We require certain information from each patient in order to begin your care. The attached forms need to be completed in order for us to get you started as our patient. Please do your best to complete all the information. If certain information does not apply to you, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payer has different guidelines for allowing coverage of <u>pediatric physical</u> therapy services. It is helpful if you let us know your healthcare payer when starting service so that we may find out if prior authorizations are needed. If you are a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payer does not cover <u>pediatric physical therapy</u> services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

#### ALASKA MEDICAID RECIPIENTS:

Alaska Medicaid requires that a physician, physician assistant or advanced nurse practitioner refer you to our practice before we can perform an initial assessment on you. After we have completed your initial assessment, we develop an individualized Treatment Plan to meet your specific therapy goals.

Your primary care practitioner will need to review & approve your Treatment Plan, and then return it to our practice before we can begin your treatment. Please understand that we cannot schedule your therapy appointments until after we have received your approved Treatment Plan.

### PRESCRIPTIONS

We do not issue prescriptions for medications. We are glad to coordinate your care through your primary care provider who has the ability to write prescriptions for you. If you feel you would benefit from the use of prescription medications, please talk with our therapist for assistance.

PATIENT NAME:	
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### NO SHOW POLICY

If you cannot make it to a scheduled appointment, please contact our office at least 24 hours in advance, some exceptions do apply. A charge of \$50 will be assessed to patient accounts for missed appointments without prior notice. This charge will not be billed to your healthcare insurance payer and is the responsibility of the patient (or parent) to pay.

### WAIT LIST FOR SERVICES

If you would like to reschedule an appointment for a day or time that is not available, please let us know and we will place you on our waiting list. If another patient cancels their appointment, we will contact patients on the waiting list on a first come, first call basis.

## MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICE.

Medicaid has a cost share amount of \$3.00 for each physical therapy visit. While this practice will not discontinue your services for non-payment of cost share amounts, it is expected that patients pay them at the time of service.

### BILLING AGENT CONTACT INFORMATION

Our practice uses a professional billing service to process your claims to healthcare payers and to arrange payment of patient balances. We have all the required agreements in place to insure that your protected health information is safe and remains confidential. If you have inquiries about your healthcare claims, monthly statements, or if you have additional billing information, you may reach our billing agent at:

<u>Fusion</u> 864-735-8816

### COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

### FINANCIAL AGREEMENT

New patients approved for physical therapy services are responsible for any and all charges not paid for by healthcare insurance payers (Medicare, Medicaid, Private Health Insurance Carriers, Worker's Compensations, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Kids Are People Too! for the services we provide to you, our valued customer. Following the receipt of your patient statement, please contact our practice to make payment arrangements. We accept cash, personal checks, money orders, We also are willing to make reasonable payment arrangements to keep your account current.

### QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either by phone or in writing; Our Manager or Practice Liaison will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

Page 2 of 3

# Kids Are People Too! LLC Pediatric Therapy

### **Cancellation Policy**

Dear Families:

In order to provide care to as many children as possible the following policy will be effective Jan 06, 2012. (revised November 29, 2018)

Please be advised that we (Kids Are People Too!) due to more frequent non emergent short notice cancellations, we will be enforcing our no show/late cancelation policy of \$50 fee per patient. We require a 24 hour notice to cancel a scheduled appointment. Appointments that is non-emergency and canceled less than 24 hours prior to schedule time will be considered "no-shows". The only exception is a child or family member who is with fever or actively vomiting/diarrhea the evening prior to or morning of scheduled time or in case of family emergency. For these missed appointments, please call as soon as possible to avoid "No Show" notice.

We would appreciate notification of other medical appointments which conflict with therapy appointment times at least 2 weeks prior to scheduled therapy appt. Please give us as much notification as possible so that we can provide necessary notification to the therapist and schedule other patients in your slot.

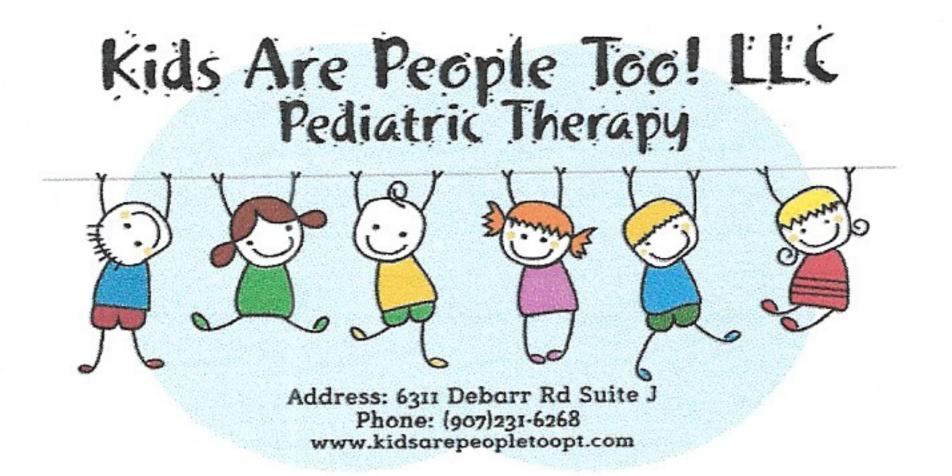
In case of inclement weather, we will be consider Any Winter Advisory Nixel reports or ASD notifications of school/ after school activity closings, before we would consider closing our doors early or for the day. So unless, we cancel due to inclement weather, we will be open and therapists will be present. It would be considered a "No Show" appointment cancelation, if you cancel your appointment for the scheduled day, without one of the 2 notices sent to the public.

Please be advised that 3 no-shows will result in your child's slot beginning made available to others and a fee of \$50 per patient will be accessed.

We appreciate your understanding and support of this cancellation policy.

By signing below you are acknowledging and accepting receipt of this policy.

Signature of Parent/Guardian	
Date	



### PATIENT AGREEMENT

Notice of Privacy Practices and your Rights

By signing below, you are acknowledging and accepting receipt of this policy.

Patient Name:	
Signature of Guardian:	
Date:	

## HIPAA AUTHORIZATION FORM

1	hereby authorize the use or disclosure of my protected health
informa	ation as described below:
	e People Too, LCC is authorized to disclose the following protected health information to all and occupational therapist, doctors and other necessary providers.
	<ul> <li>The health information that may be disclosed is:</li> <li>Medical records</li> <li>Communicable diseases (Including HIV/AIDS)</li> <li>All Treatment Records</li> <li>Other, List of Records to be shared (past, present, future periods of health care information may be shared).</li> </ul>
	Purpose of the use or disclosure: The purpose of this use or disclosure is PURPOSE OF DISCLOSURE.
3.	Validity of Authorization Form: This Authorization form is valid beginning expires on
	ACKNOWLEDGMENT: I understand that the information used or disclosed under the Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.
	I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
	Patient Name:
	Parent/Guardian Signature:
	Date: