Alight Pediatric Therapy Clinic, Inc.

ALIGHT PEDIATRIC THERAPY CLINIC, INC. (APTCI)

NEW PATIENT INFORMATION RECORD

Date: _____/_____/_____ **Referring Physician: _____**

Patient Name (First, Middle Initial, Last): _____

Home Address (If Apt., include Apt. #): _____

City: _____ **ZIP: _____** **Home Phone: _____**

Cell: _____ **Email: _____** **Other: _____**

Date of Birth _____/_____/_____ **Age: _____Sex: _____ Social Security #: _____**

Parent/Guardian Name (First, Middle Initial, Last) (Mother): _____

Parent/Guardian Name (First, Middle Initial, Last) (Father): _____

Other Person's Living In Household: _____

Home Address (If Apt., include Apt. #): _____

City: _____ **ZIP: _____** **Driver's License #: _____**

Home Phone: (____)_____ **Cell: (_____)_____** **Email: _____**

Emergency Contact (Not living at same address): _____

Home Phone: _____ **Cell: (_____)_____** **Email: _____**

COMMERCIAL INSURANCE INFORMATION

Do you have Commercial Insurance? If Yes, Plan Name: _____

Policy Number: _____ **Group Number: _____**

Policy Holder Name: _____ **Name of Employer: _____**

Date of Birth: _____/_____/_____ **Social Security #: _____**

Relationship to Patient: _____

MEDICAID INSURANCE INFORMATION

Medicaid #: _____ DOB: ____/_____/_____ Responsible Party: _____

☐ **CCP** ☐ **Amerigroup Medicaid** ☐ **Community First** ☐ **Community First Chip** ☐ **Superior** ☐ **Superior Chip**

☐ **Aetna Medicaid** ☐ **Aetna Chip**

Alight Pediatric Therapy Clinic, Inc.

PATIENT MEDICAL HISTORY

1. **BIRTH HISTORY:** Born at _____ weeks

   Length of Hospital Stay_____. Oxygen needed: ☐ Yes ☐ No

   Complications (If none write NONE)**:** _____

2. **MEDICAL HISTORY:** Check any that apply

   ☐ Hearing/Vision Impairment ☐ Eating/Swallowing Difficulty ☐ Asthma ☐ GERD

   ☐ Frequent Ear Infections/Illness ☐ Difficulty in School ☐ High Fever ☐ RSV

3. **ALLERGIES:** Are you allergic to any medications? (If None write NONE)

   Allergies to: _____

   _____

4. **SURGICAL HISTORY:** Please list any operations you've had including tonsillectomy, appendectomy, or hernias, with the year of the surgical procedure. (If none write NONE)

Operation	**Date**
_____	_____/_____/_____
_____	_____/_____/_____

5. **HOSPITALIZATIONS:** Please tell us of any non-surgical hospitalizations you've had, including heart, lung, kidney, or other serious medical problems. (If none write NONE)

Problem requiring hospitalization	**Date**
_____	_____/_____/_____
_____	_____/_____/_____

6. **MEDICATIONS:** Please tell us of all medications you are regularly taking. (If None write NONE)

Medication	**Date**
_____	_____/_____/_____
_____	_____/_____/_____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Alight Pediatric Therapy Clinic for services rendered. I recognize my financial obligation for any co-insurance or deductible and non-covered services that may be required.
RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process this claim or to assist another health professional with my care. This is a lifetime authorization.

Signature of Parent/Guardian (or responsible party) _____ **Date** ____/____/_____

Alight Pediatric Therapy Clinic, Inc.

Pediatric Policy Acknowledgment Form

1. Evaluation

-Your initial visit will involve a comprehensive evaluation in order for us to develop an individualized treatment plan.
Patients and parents/guardians play an active role on the therapeutic team.
-Patient and family goals and expectations are incorporated into the plan of treatment developed by the therapy team and communicated to the referring physician.
-The staff will demonstrate and recommend techniques and strategies to use at home and school to solidify skills learned during treatment.

2. Appointments

-Appointment times are based on therapist availability and may be subject to change. We will make every effort to accommodate your schedule to the best of our ability.
-Your child's therapist has determined the optimal amount of time for each visit.
-Clinical therapy services may be provided by a licensed therapy assistant under the direct and close supervision of a licensed and/or certified therapist.
-The assistant will follow the treatment plan designed by the supervising therapist. Any necessary changes and updates will be performed by the supervising therapist.

3. Attendance/Timeliness

-Regular attendance is important to obtain maximum benefits from your therapy. Following **three consecutive absences** or a **pattern of absenteeism**, the therapist will recommend discharge from the program.
-Please notify the clinic 24 hours in advance of an appointment cancellation.
-Patients with **two consecutive No Show** appointments are subject to discharge from therapy.
-Promptness is appreciated. Patients arriving 15 minutes or more past their therapy time may not be seen, as this interferes with our ability to address goals.
-If tardy to a session, no extension may be given and the session will end at the regularly scheduled time.
-We strive to provide a healthy environment for our other patients and our staff. If your child has a contagious illness, we ask that you please cancel accordingly.

4. Supervision

-One parent/guardian or other adult responsible for the child **must remain** at the facility throughout the therapy session(s). Occasionally a child may be unable to complete the full session of therapy. In those instances, it is necessary to have a parent or guardian available to attend to the child's needs.
-Parents are responsible for the patient, siblings, and other children brought to the clinic and **must** supervise them. We care about your kids and want to ensure their safety.

5. Behavior

-For therapy to be effective, rules must be implemented and followed in the treatment session. Therapists may use "time out" as a discipline tool.
-When behavior is disruptive, therapy is not effective. If your child is unable to participate in therapy due to behavior issues, the session will end early.
-If your child engages in injurious behavior towards him/herself or the therapist, the therapist will end his/her session immediately.
-Therapists reserve the right to discontinue services based on continuous behavioral disruption.

6. Communication

-Parents are encouraged to participate in therapy and communicate concerns to therapists. If a concern cannot be resolved with the therapist, parents can request to speak with the Supervisor of Therapy.
-A discharge summary will be sent to your child's physician upon completion of his/her course of therapy.

I have read the above Policy Acknowledgment Form, and fully understand and agree with the statements therein.

Signature of Parent or Guardian _____ Date _____/_____/_____

Alight Pediatric Therapy Clinic, Inc.

Consent to Photograph or Record (please check all that apply)

☐ I grant Alight Pediatric Therapy Clinic to right to photograph or take video of my child for use in clinical observation or for placement in marketing materials (website, flyers, clinic walls, etc.)

☐ I grant Alight Pediatric Therapy Clinic the right to photograph or take video of my child for clinical use only.

☐ I prefer that no photographs or video recordings of my child be taken.

Signature: _____ Patient Name:_____ Date: _____

Alight Pediatric Therapy Clinic, Inc.
6996 S. Zarzamora Ste. 1
San Antonio, TX 78224
Phone: (210) 787-1583
Fax: (210) 921-0009

Date: _____/_____/_____

To whom it may concern:

_____ has been evaluated and is to receive

_____ here at Alight Pediatric Therapy Clinic, Inc. Please discontinue authorization at the previous facility.

The previous facility was:_____.

Phone #: (_____)_____

Date of last patient visit at previous facility: _____/_____/_____

Included is all evaluation paperwork and request for current authorization.

_____ _____
Parent Signature **Date**

Thank You,

Alight Pediatric Therapy Clinic, Inc.

Alight Pediatric Therapy Clinic, Inc.

CONFIDENTIAL RELEASE OF INFORMATION

PATIENT: _____ **DOB:** _____/_____/_____

I hereby grant permission for confidential medical/ school records concerning the above named person to be released to Alight Pediatric Therapy Clinic, Inc. (APTCI)

_____ _____/_____/_____
Signature of Patient, Parent or Guardian **Date**

****

I hereby grant permission for confidential medical records concerning the above named person to be released from the Alight Pediatric Therapy Clinic, Inc. (APTCI) to Team Members and concerned parties for medical and/or developmental follow-up, and also to the following:

1._____

Address: _____

2._____

Address: _____

3._____

Address: _____

4._____

Address: _____

_____ _____/_____/_____
Signature of Patient, Parent or Guardian **Date**

Alight Pediatric Therapy Clinic, Inc.

FINANCIAL AGREEMENT

- Alight Pediatric Therapy Clinic will be responsible for verification of benefits prior to initial evaluation.

- Alight Pediatric Therapy Clinic will be responsible for billing primary insurances for payment.

- Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, and Master Card. **Please understand that you are financially responsible for all charges whether or not they are paid by insurance.**

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. **Please note insurance companies may indicate the services were not medically necessary and claims that because Alight Pediatric Therapy Clinic is a preferred provider you do not have to pay the balance, this is NOT the case and you will be billed for the services.** This office can not accept responsibility for negotiating settlements on disputed claims.

- Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. As a courtesy to our patients we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I hereby understand the above financial policy and agree to abide by it.

_____ _____

Signature Date

Alight Pediatric Therapy Clinic, Inc.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight:

Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation:

Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Alight Pediatric Therapy Clinic, Inc.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Your signature below indicates you have received a copy of Alight Pediatric Therapy Clinic Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in Alight Pediatric Therapy Clinic Notice of Privacy Practices, please do not hesitate to contact Alight Pediatric Therapy Clinic Patient Privacy Officer as indicated on your Notice.

Patient Name: _____

Patient Representative: _____

Relationship: _____

Signature: _____

Date: _____

Alight Pediatric Therapy Clinic, Inc.

Resource Assessment

Child: _____

Parent/Guardian: _____

Phone Number: _____

1. Are you familiar with specials educations services through the public schools?

   Yes / No – Comments: _____

2. Does your family need any assistance with basic or financial needs (food, clothing, etc.)?

   Yes / No – Comments: _____

3. Do you feel that you have a good support system and have someone you can talk too?

   Yes / No – Comments: _____

4. Does your family need any support services in the area (counseling, support groups)?

   Yes / No – Comments: _____

5. Are there any services that you are having trouble finding in the community?

   Yes / No – Comments: _____

6. Has there been a change in your child's performance at school that you are concerned about?

   Yes / No – Comments: _____

7. Are there any behavioral issues that have not been addressed, that concern you?

   Yes / No – Comments: _____

8. Are you interested in scheduling an appointment with our Case Manager to discuss your concerns?

   Yes/No- Comments:_____