

DIRECTORS

JANE KAPLAN HULL, P.T., M.P.H.

SARA WEISER, OTR/L

Tel: (703)536-1817

Fax: (703)536-5677

Email: info@gbtherapy.org

Website: www.gbtherapy.org



6521 Arlington Blvd., Suite 312

Falls Church, VA 22042

427 Carlisle Drive

Herndon, VA 20170

A Therapeutic Approach To
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PATIENT DEMOGRAPHIC INFORMATION

CHILD'S NAME: _____

MEDICAL /ALLERGIES: _____

CHILD'S DIAGNOSIS: _____ DATE OF BIRTH: ___/___/___

PEDIATRICIAN NAME AND PHONE NUMBER: _____

PARENT NAME(S): _____

ADDRESS: _____

E-MAIL ADDRESS: _____
(We will NOT share this information with anyone outside Good Beginnings.)

TELEPHONE: Home: _____ Cell(s): _____

Work (Mom): _____ (Dad): _____

INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

INSURED'S NAME: _____ DATE OF BIRTH: ___/___/___

INSURANCE CO.: _____

GROUP #: _____ ID #: _____

INSURED'S SOCIAL SECURITY #: _____

CLAIMS ADDRESS: _____

For office use only: ICD-9:code 1 _____ code 2 _____ code 3 _____
Please Circle: OT or PT

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PATIENT HISTORY

Child's Name:

Date of Birth:

Diagnosis:

Referring Physician:

Birth History (i.e., gestation, delivery vs. c-section, NICU stay, complications):

Medical History (Please include any surgeries or illnesses):

Medications/Allergies:

Has your child ever seen PT/OT/speech? YES / NO

If yes, where and when?

Developmental History:

Age when child began: rolling _____ sitting _____
crawling _____ walking _____

Were speech and/or other developmental delays present at or before age 2?

School: _____ ***Grade:*** _____

Does your child have an IEP? Yes _____ No _____

Class placement: (please check) Regular Ed. _____ Special Ed. _____ Both _____

School services received: OT _____ PT _____ Speech _____ Home Resource _____ Other: _____

List any medical specialists your child has seen (neurologists, psychologists, etc.):

Please describe your goals for your child, and what you would like him/her to achieve at Good Beginnings:

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AUTHORIZATION FOR RELEASE OF INFORMATION

Yes **No**

___ ___ I authorize release of information to all my insurance companies.

___ ___ I authorize Good Beginnings to act as my agent in helping me to obtain payment from my insurance companies.

___ ___ I authorize release of Good Beginnings records and other relevant information to my child's pediatrician, medical specialists, and school personnel. *

___ ___ I authorize my child's pediatrician, medical specialists, and school personnel to release relevant records and information to Good Beginnings.

___ ___ I authorize my child's therapist to speak with me about his/her treatment in Good Beginnings' waiting room. **

___ ___ I permit a copy of this authorization to be used in place of the original.

___ ___ I permit Good Beginnings staff, in an emergency when I cannot be contacted, to take my child to the nearest hospital emergency room for treatment.

___ ___ I authorize my spouse and _____ to obtain information in my stead.

NAME: _____ FOR: _____
(Please print your name) (Patient name – please print)

SIGNATURE: _____ DATE: _____

* You may/may not (circle one) release records/information to:

** If answered "no", please discuss alternatives with the therapist.

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GOOD BEGINNINGS FINANCIAL POLICY

PLEASE READ CAREFULLY BEFORE SIGNING

1. **Cancellation and attendance policy:** Please refer to separate document.
2. **Your child's therapy is a serious commitment between you and his/her therapist.** Good Beginnings requires consistent attendance to maximize your child's progress. In consideration of your therapist who receives compensation only for clients seen, we reserve the right to terminate therapy in the event that appointments are not attended as scheduled, or if your bill is not paid in a timely manner.
3. **If Good Beginnings DOES NOT have a contract with your insurance company,** payment is due at the time services are rendered. Our offices are not able to accept cash payment at this time. You should pay your therapist by check. Claim forms for you to submit to your insurance company and receipts for flexible spending accounts should be requested through our billing office at 1-877-698-1700. Your therapist is unable to generate these items for you, but can provide a simple receipt of payment when funds are received.
4. **If Good Beginnings DOES have a contract with your insurance company,** we will submit your claim to your insurance company. It has become impossible, however, for our staff to be familiar with the separate requirements, and keep up with changes, of each individual or group health care plan. If you are, or you become, a member of any health care plan, ***it is your responsibility to know what your health care plan will cover and to abide by its rules regarding services in our office as well as referrals, preauthorizations, etc. If you have questions about what your health care plan will and will not cover, you need to contact your plan directly. You are responsible for making your co-payment with your therapist at every visit.*** Our offices are not able to accept cash payments. Please pay your therapist by check. Please note that it takes **at least one week** to generate a referral or preauthorization (except in case of emergencies). You are responsible for notifying us of any changes regarding insurance coverage. We are not responsible for obtaining preauthorization for therapy services if we are not informed of current insurance coverage and you are responsible for any non-covered and/or denied charges incurred on your child's behalf.
5. **Good Beginnings will not file claims with secondary insurance companies.** We will prepare a bill for you to do so, and you will be responsible for paying the balance after your primary insurance company has paid its share.
6. Some insurance companies are requesting frequent and lengthy reports for therapy authorization. You may be billed for the cost of providing these reports since this service is not covered by insurance. You will be billed at office visit rates if you request that a therapist write any report beyond the usual. You will be billed at home visit rates if you request that a therapist attend meetings on your behalf. If we provide other services not covered by your insurance carrier, you will be responsible for full payment.
7. You will be billed a \$30.00 fee for each check returned by the bank.
8. In the event that an account is taken to a collection agency or court, you are responsible for all collection and/or attorney fees incurred by Good Beginnings, Inc.

I authorize GOOD BEGINNINGS to apply for benefits on my behalf for covered services rendered. I request payment to be made directly to GOOD BEGINNINGS. I certify that the information I have provided with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for any related claim, to Good Beginnings' billing agent and/or my insurance carrier. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing at any time by either me or my insurance carrier.

I have read the above policy and agree to abide by it.

(Parent Signature)

(Date)

(Child's Name – please print)

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11. **If Good Beginnings DOES NOT have a contract with your insurance company,** payment is due at the time services are rendered. Our offices are not able to accept cash payment at this time. You should pay your therapist by check. Claim forms for you to submit to your insurance company and receipts for flexible spending accounts should be requested through our billing office at 1-877-698-1700. Your therapist is unable to generate these items for you, but can provide a simple receipt of payment when funds are received.
12. **If Good Beginnings DOES have a contract with your insurance company,** we will submit your claim to your insurance company. It has become impossible, however, for our staff to be familiar with the separate requirements, and keep up with changes, of each individual or group health care plan. If you are, or you become, a member of any health care plan, ***it is your responsibility to know what your health care plan will cover and to abide by its rules regarding services in our office as well as referrals, preauthorizations, etc. If you have questions about what your health care plan will and will not cover, you need to contact your plan directly. You are responsible for making your co-payment with your therapist at every visit.*** Our offices are not able to accept cash payments. Please pay your therapist by check. Please note that it takes **at least one week** to generate a referral or preauthorization (except in case of emergencies). You are responsible for notifying us of any changes regarding insurance coverage. We are not responsible for obtaining preauthorization for therapy services if we are not informed of current insurance coverage and you are responsible for any non-covered and/or denied charges incurred on your child’s behalf.
13. **Good Beginnings will not file claims with secondary insurance companies.** We will prepare a bill for you to do so, and you will be responsible for paying the balance after your primary insurance company has paid its share.
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16. In the event that an account is taken to a collection agency or court, you are responsible for all collection and/or attorney fees incurred by Good Beginnings, Inc.

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GOOD BEGINNINGS ATTENDANCE/CANCELLATION POLICY

Regular attendance is essential for your child's growth in therapy. Your decision to contract services is a commitment to your child and your child's therapist. We maintain a strict cancellation policy, as outlined below, to keep costs down and to assure efficient use of our therapist's time and skills.

- Good Beginnings will allow your child to miss any **THREE** therapy sessions during a 6-month period, with no charge, for any reason (i.e. illness, vacation, medical appointments or scheduling conflicts), as long as notice is given to the treating therapist. All missed sessions that exceed the three appointments discussed above will be charged to you at our hourly rate of \$120*.
- Any visit that is completely disregarded and missed without notice to your therapist will be considered a No-Show and your account will be assessed a fee of \$120*.
- Good Beginnings reserves the right to deny an ongoing therapy slot to any client who is not regularly attending therapy.
- All cancellation and No-Show fees will be billed directly to you. Neither your insurance company nor your flexible spending account will cover these fees.
- We understand that keeping a weekly appointment can be challenging. If you find that you are having trouble keeping your appointment time with your therapist, we will be happy to see you on an "as available" basis or as your therapist's schedule permits.
- We require one week's notice to discontinue therapy altogether to allow your child to transition properly and give us time to fill the slot with another child.

WEATHER POLICY

Each therapist will make a determination as to her availability for therapy during unusual weather conditions. If you do not receive a phone call canceling your therapy session, assume that it will be held as scheduled. Please call your therapist's extension to cancel any session.

SICK POLICY

Your child must be cleared of all sickness and fever for a 24-hour period prior to receiving therapy.

Our offices have 24-hour voicemail. You may call at any time during the day or night to notify Good Beginnings that you need to cancel your child's session. Please make sure you speak with your therapist to discuss his/her preferred method of contact and to obtain his/her phone number and voicemail box number. This is a Good Beginnings policy. All questions regarding this policy should be directed to our practice manager at 703-536-1817 x 201.

This policy is effective 9/1/2010.

By signing below, I acknowledge receipt of this cancellation policy and agree to the terms stipulated above.

(Parent Signature)

(Date)

(Child's Name – please print)

* Fees subject to change

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NOTIFICATION OF FEES

The cost of a complete physical therapy evaluation is \$270*. The evaluation includes testing, scoring, and interpretation of results. In the event there are multiple areas of concern, extended evaluation time may be required. In this case, the child will be asked to return for more testing which will incur an additional charge to be billed separately.

I, _____, have read and understand the Good Beginnings Financial Policy. I understand that due to the specialization of the services provided by Good Beginnings I will be responsible for services not covered by my insurance carrier including, but not limited to, co-pays, deductibles and non-covered services.

(Parent Signature)

(Date)

(Child's Name – please print)

FOR KAISER AND UNITED HEALTH CARE CLIENTS ONLY

_____ I understand that my insurance carrier will not pay for a formal written assessment. I would like a written assessment on my child for the amount of \$360.00* and agree to pay for it in full at the time of service.

_____ I would NOT like a written assessment on my child.

(Parent Signature)

(Date)

(Child's Name – please print)

**Fees subject to change*

September 2010

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES*

I, _____, have read and received a copy of Good Beginnings Privacy
(Please print full name)

Practices.

(Parent Signature)

(Date)

(Child's Name – please print)

*Attachment: Notice of Privacy Practices

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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.

GOOD BEGINNINGS is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Uses and Disclosures: Good Beginnings uses health information about you for treatment to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive at Good Beginnings. Information may be shared by paper mail, electronic mail, fax or other methods. Any identifiable or health information about you will be disclosed only with written authorization.

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example: *On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with GOOD BEGINNINGS. It is our policy to provide a substitute health care provider, authorized by GOOD BEGINNINGS to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation.*

Your Rights: Unless otherwise required by law your health record is the physical property of the health care practitioner or facility that compiled it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice. Good Beginnings reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Good Beginnings is required by law to comply with this Notice. For more information about our privacy practices, please call our office at 703-536-1817.

Complaints: Complaints about your Privacy rights, or how Good Beginnings has handled your health information should be directed to Sara Weiser by calling this office at 703-536-1817 ext. 201. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to the U.S. Department of Health and Human Services.

Payment: Your protected health information will be used by Good Beginnings, as needed, in activities related to obtaining payment for your health care services. We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Business Associates: Good Beginnings will share your protected health information with third party business associates that perform various activities (billing, transcription, fabrication of orthotics, other medical equipment). When these services are contracted, Good Beginnings will require the business associate to appropriately safeguard your information.

Other purposes that are permitted or required by law: We may disclose your child's PHI without your authorization when required to do so by federal, state, or local law, in matters of public health issues, to avert a serious threat to health or safety, to report abuse or neglect, in legal proceedings such as lawsuits or disputes, to law enforcement, workers' compensation, research, medical examiners, to conduct health oversight investigations, in matters of national security and intelligence activities, military activity, criminal activity, and required uses and disclosures.

Effective Date: This notice will be effective from November 1, 2008