Directors

SARA WEISER, *OTR/L*
Tel: (703)536-1817
Fax: (703)536-5677
Email: info@gbtherapy.org
Website: www.gbtherapy.org

G·O·O·D BEGINNINGS

A Therapeutic Approach To
Movement & Learning

Locations
6231 Leesburg Pike, Suite 500
Falls Church, VA 22044

150 Elden Street, Suite 270
Herndon, VA 20170

PATIENT APPLICATION FOR THERAPY

TODAY'S DATE: CHILD'S NAME: GENDER: M / F

DIAGNOSIS: DATE OF BIRTH: **ALLERGIES: NO / YES List:**

PARENT/GUARDIAN NAME(S):

ADDRESS:

PRIMARY PHONE: MOBILE / HOME / WORK MOM / DAD / OTHER

SECONDARY PHONE: MOBILE / HOME / WORK MOM / DAD / OTHER

EMERGENCY PHONE: MOBILE / HOME / WORK NAME:

EMAIL: NAME:

INSURANCE INFORMATION:

INSURANCE COMPANY: POLICY/ID #:

INSURED'S NAME: GROUP #:

INSURED'S SS#: INSURED'S DOB:

INSURED'S EMPLOYER: & ADDRESS:

CLAIMS ADDRESS:

PHYSICIAN INFORMATION:

PEDIATRICIAN/PRIMARY CARE PRACTICE:

LOCATION (if multiple): PHONE #: FAX #:

PRIMARY DOCTOR SEEN:

For office use only: ICD-10 Code 1: Code 2: Code 3: Code 4: PT OR OT

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PATIENT HISTORY - PT

Child's Name: _____ ***Date of Birth:*** _____

Birth History:
Birth Weight: _____ Which pregnancy was this child? _____ Adopted, &,if so, when? _____

Patient was born at gestational age of _____weeks via □ C-section □ Vaginal
If birth was vaginal, was it completed with □ Forceps? □ Vacuum extraction? □ N/A

Were there any complications at birth? _____ If so, how were they resolved?

_____

Postnatal: □ Jaundice □ Required Oxygen □ Surgery □ Sucking or swallowing problems □ NICU

Current height percentile: _____ Current weight percentile: _____

Medical History
Are immunizations up to date? □ YES □ NO Known allergies: _____
List all medications and dosages currently prescribed for the patient (ex., Amoxicillin, 1 tsp./2x daily):

_____

Please check the following as they apply to your child:

□ Low birth weight	□ Hearing loss	□ 3 or more ear infections	□ Allergies (sinusitis, food, etc.)
□ Seizure disorder	□ Asthma	□ Gastric reflux	□ Cerebral Palsy
□ Surgeries	□ ADD/ADHD	□ Tonsillitis	□ Other: _____

Motor Development:
Does your child seem overly awkward, uncoordinated or clumsy? □ YES □ NO
Does your child lose his/her balance or fall easily? □ YES □ NO
Does your child display hand preference? □ YES □ NO If so, which hand? □ Left □ Right
Did your child:

Hold his/her head up by 4 months?	□ YES □ NO	If no, age in months: ____	□ N/A
Sit alone by 6 months?	□ YES □ NO	If no, age in months: ____	□ N/A
First crawl by 12 months?	□ YES □ NO	If no, age in months: ____	□ N/A
First walk alone by 16 months?	□ YES □ NO	If no, age in months: ____	□ N/A
Potty-train by 3 years?	□ YES □ NO	If no, age in months: ____	□ N/A
Feed him/herself by 2 years?	□ YES □ NO	If no, age in months: ____	□ N/A
Use scissors by 3 years?	□ YES □ NO	If no, age in months: ____	□ N/A
Grasp crayon/pencil (thumb & finger) by 3 years?	□ YES □ NO	If no, age in months: ____	□ N/A

PATIENT HISTORY – PT (continued)

Child's Name: _____

Please check any/all areas of difficulty (as appropriate for age):

- □ Lifting head while on stomach
- □ Rolling over
- □ Sitting alone
- □ Creeping on hands & knees
- □ Accepting weight into legs
- □ Standing at furniture
- □ Standing alone
- □ Bearing weight on arms
- □ Pulling to sit/stand
- □ Throwing ball overhand
- □ Walking/running/jumping
- □ Walking up/down stairs
- □ Balancing/hopping on one foot
- □ Hopping/jumping
- □ Bringing hands together at midline
- □ Transferring objects from hand to hand
- □ Building towers with blocks
- □ Copying shapes
- □ Cutting on a line around a shape
- □ Walking backwards

Care/Educational History:

Please check any/all as they apply to your child:

- □ At home with parent
- □ At home with nanny/au pair/other caregiver
- □ Daycare in home
- □ Daycare at center/via Early Intervention
- □ Preschool
- □ K – 5th grade
- □ 6th grade & up

Current school/program: _____ Grade: _____

Type of classroom: □ Regular □ Exceptional Student Special Program □ Other

Does your child have an IEP? □ YES □ NO

Does your child receive the following school services? □ PT □ OT □ Speech □ Tutoring □ 504 Plan

Social/Emotional Development:

Please check any/all as they apply to your child:

□ Overly active	□ Underactive/very shy/overly quiet	□ Eating difficulties; unusual eating habits
□ Poor eye contact	□ Poor memory	□ Sleeping difficulties
□ Interrupted/unusual sleeping habits	□ Plays alone for reasonable amount of time	□ Avoids group play; prefers to play alone
□ Friendly/outgoing	□ Easily frustrated	□ Falls/trips frequently
□ Destructive/aggressive	□ Pretend play	□ Imitates actions/gestures/speech
□ Appropriate turn-taking skills	□ Appropriate use of objects	□ Difficulty with transitions
□ Difficulty separating from parent	□ Difficulty concentrating	□ Plays with toys appropriately

Does your child receive the following services outside of school? □ PT □ OT □ Speech □ Tutoring

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GOOD BEGINNINGS AUTHORIZATION FORM

I, _____, state that I am the parent and/or legal guardian of _____
(Your name - please print) (Patient's name – please print)
and, acting in such manner, I authorize the following:

Yes **No**

___ ___ I authorize Good Beginnings' staff to provide occupational and/or physical therapy to the minor patient named above, and named in the attached forms, while I am not present.

___ ___ I authorize Good Beginnings' staff, in the event of an injury, illness or other emergency, when I cannot be contacted, to administer the necessary medical treatment to my child. This treatment may include, but is not limited to, the following: cold packs, general first aid, CPR, EMT, ambulance services, arranging transportation and/or treatment at the nearest hospital emergency room. **

___ ___ 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 co.

___ ___ 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 the waiting room. **

___ ___ I authorize any Good Beginnings' students and/or volunteers to observe my child's therapy session. **

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

___ ___ I authorize my spouse, my child's other parent, guardian and/or _____ to obtain information in my stead. *(Please indicate the name of other parent, grandparent, nanny, caregiver, etc. if someone else will be bringing your child to therapy and you would like the therapist to be able to speak with them).*

NAME: _____ FOR: _____
(Your name – please print) (Patient name – please print)

SIGNATURE: _____ DATE: _____

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

** If you answered "no", please discuss alternatives with your child's therapist.

February 2018

GOOD BEGINNINGS FINANCIAL POLICY

PLEASE READ CAREFULLY BEFORE SIGNING

1. **If Good Beginnings DOES have a contract with your insurance company:**
   a. Claims will be submitted directly to your insurance company on your child's behalf. You will receive an explanation of benefits (EOB) directly from your insurance company explaining how the claim was processed. You will then receive an invoice from Good Beginnings regarding any balance remaining after insurance claim adjudication. Invoices are sent every 30 days.
   b. Any applicable co-pays will be collected at the time of service.
   c. You are responsible for checking benefits and any terms related to specific coverage policies.
   d. If pre-authorization is required, it is your responsibility to notify Good Beginnings so we can assist with any necessary documentation. If we are not notified and claims deny for lack of authorization, you will be responsible for the session(s).
   e. Changes to insurance status and coverage need to be shared immediately with our billing office. You will be invoiced directly for any claims denied by your insurance.
   f. Overdue balances not settled within 60 days from date of service (i.e. due to deductible, non-covered services, etc.) will be charged to the credit card on file. You are welcome to send a check with your invoice at any time.

2. **If Good Beginnings DOES NOT have a contract with your insurance company:**
   a. We require a credit card on file to auto charge any remaining balances not covered by your insurance company. As a courtesy, we will handle filing claims directly to your insurance company. All credit card information is stored in our secure vault. A receipt for the services will be emailed to the email address on file. Credit cards will be auto charged every 60 days to allow time for any insurance adjudication for your claim.
   b. If you have not placed a credit card on file, please contact our Billing Manager at 240-329-9007 as soon as possible. Otherwise, you will be required to pay in full at each session and Good Beginnings will provide you with 'self-submit' claim form(s) to use for reimbursement purposes.
   c. You are responsible for checking benefits and any terms related to specific coverage policies.
   d. If pre-authorization is required, it is your responsibility to notify Good Beginnings so we can assist with any necessary documentation. If we are not notified and claims deny for lack of authorization, you will be responsible for the session(s).
   e. Changes to insurance status and coverage need to be shared immediately with our billing office. You will be invoiced directly for any claims denied by your insurance.

3. Good Beginnings will not submit claims to secondary insurance policies**.** However, we will provide a detailed invoice which you can use to submit to your secondary insurer. You will be responsible for paying the patient portion after your primary insurer has paid their portion.

4. Additional reports/form completion/extra documentation beyond the therapy session will be billed at the hourly therapist rate in 15 minute increments. Please note, these fees are typically not covered by insurance companies.

5. Parent meetings are not covered by insurance companies and will be billed at the hourly therapist rate. Extended meetings will be billed in 15 minute increments beyond the initial hour.

6. Good Beginnings charges $40.00 for each check returned by the bank.

7. Any credit cards kept on file will be kept in a secure vault. A receipt will be emailed to the parent email on file.

8. Please let our Billing Dept. know if you require an itemized printout for HSA, Flex Spending or Tax purposes.

9. In the event that your account is forwarded to our collection agency, you may be responsible for a 25% collection fee, interest in the amount of 6%, court costs, and attorney fees as permitted by Virginia State law.

10. Good Beginnings may suspend therapy sessions for any patient balances exceeding $500.00. Our Billing Dept. can assist you with payment arrangements if necessary.

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 if appointments are not attended as scheduled, or if your bill is not paid in a timely manner. Please see our separate attendance policy for details.

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 records 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/Guardian Signature (Seal)	**Date**	**Child's Name – please print**

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ATTENDANCE/CANCELLATION POLICY

Regular attendance is essential for your child's growth in therapy. We maintain a strict cancellation policy to keep costs down, and to assure efficient use of our therapists' time and skills.

Please initial next to each statement below:

_____ Weekly reserved appointments are booked in 6-month windows. **THREE** missed or canceled therapy appointments are allowed with no charge for any reason during the 6-month period. These include pre-scheduled conflicts, vacations, illness, other medical appointments, etc. Making up a session, or rescheduling a conflict in advance, is highly encouraged.

_____ All missed sessions that exceed 3 sessions within the 6-month period will be charged at $145* per session.

_____ For those scheduling a single appointment only, cancellation notice must be received within 24 hours of the appointment or a late cancellation fee of $72.50* will be charged.

_____ Notice of less than 4 hours will be charged a late cancellation fee of $72.50*. All missed appointments without notice to your therapist will be considered a No-Show and your account will be assessed a fee of $145*. All cancellation and No-Show fees will be billed directly to you.

_____ Good Beginnings reserves the right to deny an ongoing therapy slot to any client who is not regularly attending therapy. We also reserve the right to charge you directly for any missed portion of a therapy session as this time cannot be billed to your insurance company.

_____ Good Beginnings requires 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.

_____ Good Beginnings is closed on the following holidays: New Year's Day, Memorial Day, 4th of July, Thanksgiving Day, and Christmas Day.

If you find that you are having trouble consistently attending your appointment time, we will be happy to see your child on an "as available" basis, or as your child's therapist's schedule permits. Please speak with your child's therapist, or call our office (703-536-1817, ext. 100), about this.

WEATHER POLICY

We post clinic-wide updates on our Facebook page. Please go to **www.facebook.com/GoodBeginningsTherapy/** if inclement weather is expected. Each therapist will determine if she can safely be available for therapy during unusual weather conditions. **If you do not receive a phone call canceling your child's therapy session, please assume that it will be held as scheduled.** Please contact your therapist directly to cancel any session.

ILLNESS POLICY

Your child must be cleared of all sickness and fever for a 24-hour period prior to receiving therapy. In addition, all siblings/families/friends in the waiting room should be free of illness. Please be mindful during times of widespread illness, and reschedule your appointment. If your therapist thinks that your child is sick and/or contagious, he or she will be sent home.

Please contact your therapist immediately if you find that your child has been exposed to any of the following within 24 hours of your child's appointment: lice, pink eye (conjunctivitis), flu, strep throat, hand/foot/mouth disease. **All cancellations and rescheduled appointments must be made directly with your therapist.** Please talk with your therapist regarding the best way to contact her.

By signing below, I acknowledge receipt of Good Beginnings' attendance/cancellation, weather and sick policies and agree to the terms stipulated above.

NAME: _____ FOR: _____

(Your name – please print) (Patient name – please print)

SIGNATURE: _____ DATE: _____

** Fees subject to change*

February 2018

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NOTIFICATION OF FEES (PT)

The cost of a complete physical therapy evaluation is $318.75*. The evaluation includes clinical observations and impressions/analysis by the therapist. 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. You may ask for a copy of the evaluation notes; formal reports written outside of the evaluation session are subject to an additional fee.

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)

**Fees subject to change*

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Acknowledgement of Receipt of Privacy Practices*

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

_____ _____
Signature Date

*Attachment: Privacy Practices

HIPAA Authorization for Alternative Communication Means

I authorize Good Beginnings' staff to contact me and leave a message by any of the following alternative means of communication regarding my protected health information including change of appointment times, information regarding my child's performance in session, etc.

☐ Home: _____
☐ Work: _____
☐ Cell: _____
☐ Email: _____
☐ Other: _____

☐ YES, I would ☐ NO, I would not like to receive emails from Good Beginnings regarding new programming, classes, parent support opportunities, and more. Please check the YES box to be added to our email list, which shares new information BEFORE our social media outreach! (Your email will not be shared with anyone outside of Good Beginnings.)

_____ _____
Signature Date

February 2018

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GOOD BEGINNINGS, INC
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. 100. 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