Directors

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

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

150 Elden Street, Suite 270
Herndon, VA 20170

A Therapeutic Approach To

Movement & Learning

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

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

Birth History *(Please check all that apply. Complete to the best of your memory):*
_____ Delivery ______ C-section ______ Gestation: ____ weeks
_____ Time spent in NICU: ____________ ______ Apgar scores: _____
_____ Mom on bedrest ______ Assisted pregnancy _____ Adoption
Any other complications:____

Medical History *(Please check all that apply. Include surgeries &/or illnesses. Complete to the best of your memory):*
_____ Reflux _____ Feeding difficulties _____ Ear tube placement _____ Cranial orthosis
_____Other: ____

Family History:
Does your child live with both parents? ___ One parent?___ Other arrangement?___________________
# of siblings: ____ Gender & age(s): _________________________
Siblings developing typically? YES / NO If no, please explain:_________________________________

Developmental History:
Age when child began: rolling ________ sitting ________ crawling ________ walking ________
Were speech and/or other developmental delays present at, or before, age 2?

Does your child attend school? YES / NO Where and what 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: _________
Does your child currently take any medications? *YES / NO If yes, please list:*

Does your child have any allergies? *YES / NO If yes, please list:*

Has your child ever had PT/OT/speech? *YES / NO If yes, where and when?*

Please 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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PATIENT HISTORY (continued)

Child's Name: ___________________________

Other Information:
Sleep:
What is your child's typical bedtime? ____________________ Wake-up time?_____________________
On average, how many hours of sleep does your child get per night? ___________________________
Does your child wake up on his own? YES / NO
Does your child seem well-rested? YES /NO

Nutrition:
Does your child eat a varied diet including fruits, vegetables, protein, dairy and grains?
(*If so, or if there are no concerns, please skip this section.*)

- What are your child's preferred food textures? Crunchy Chewy Smooth Soft Mixed (ground meat, cottage cheese, casseroles, etc.)
- Does your child avoid any of the following textures? Crunchy Chewy Smooth Soft Mixed (ground meat, cottage cheese, casseroles, etc.)
- What are your child's preferred tastes? Sweet Salty Spicy Sour Mild Strong
- Do you sit down for family meals? YES / NO
- Are there any cultural or dietary considerations we should be aware of? YES / NO Explain: _____________

Dressing:
Please describe your child's dressing routine (include how much assistance is needed, length of time, preference for certain fabrics/avoidance of fabrics): ____

____

Can your child: fasten snaps? _________ button? _________ zip zippers? _________ buckle? _________
use Velcro closures? _________ tie shoes? _________

Activity:
Please list 3 of your child's preferred leisure activities: ____

____

How much screen-time (television, hand-held device, computer, etc.) does your child have daily? _________

____

Are there activities your child actively avoids? ____

____

What are your child's favorite play themes? ____

What motivates your child? ____

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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. Good Beginnings will handle submitting insurance claims to your primary insurance company. This includes, as a courtesy, insurance companies that we are not contracted with. Your insurance company will send you an EOB (Explanation of Benefits) indicating how your claim(s) was processed. You can also check the status of your claim(s) online with your insurance carrier.

2. Any applicable co-pays or co-insurance amounts will be collected at the time of service.

3. We require a credit card on file to secure your first appointment and as a backup payment method for any past due invoices. Credit card information is kept in a secure vault

4. You will be invoiced for any remaining balances after insurance processing. Invoices are mailed every 30 days and are due upon receipt. Balances exceeding 30 days are subject to 7% interest fees. Balances exceeding 60 days may be charged to the credit card on file. We accept Cash, Check, Credit Cards (Visa, Mastercard & Discover) and/or you can pay online via our website at www.gbtherapy.org.

5. We do our best to maintain awareness of the everchanging insurance company requirements. Please note, you are responsible for verifying your specific insurance benefits and any terms related to specific coverage policies.

6. If pre-authorization or a referral is required by your insurance company, it is your responsibility to notify Good Beginnings so that we can assist with any necessary documentation requirements. If we are not notified and claims deny for lack of authorization or referral, you will be held responsible for the cost of the session(s).

7. Changes to insurance status and coverage need to be shared immediately with our billing office. You will be invoiced directly for any charges denied by your insurance company.

8. Good Beginnings does not submit claims to secondary insurance policies**.** However, we will provide a self-submit claim form which you can send to your secondary carrier for reimbursement. You will be responsible for paying the patient portion after your primary insurer has paid their portion.

9. Additional reports, completion of forms and/or 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.

10. 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.

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

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

13. In the event that your account is forwarded to a collection agency due to non-payment, 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.

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

15. Late Arrivals and early departures: Good Beginnings cannot bill your insurance company for any reserved time missed due to arriving late or leaving a session early. You will be billed $36.25 per 15 minute increments for missed session times.

16. Attendance/cancellation policy: Please refer to our separate document.

Our billing office can be reached at 240-329-9007 or via email at Billing@GBtherapy.org.
Please be aware that communicating via email regarding insurance/billing matters may sometimes contain you or your child's PHI (Protected Health Information). Your privacy is important to us so please be mindful of the email content.

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.

I authorize Good Beginnings to apply for insurance benefits on my behalf for covered services rendered. I request payment to be made directly to Good Beginnings by my insurer. 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 Beginning's billing agent and/or my insurance carrier. I understand that Good Beginnings may occasionally email me regarding insurance and/or billing matters. I am aware that some emails may contain limited PHI (Protected Healthcare Information) and agree to this form of communication. 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 me and/or the policy holder of my child's insurance.

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

______________________________	____________	______________________________
Parent/Guardian Signature (seal)	**Date**	**Child's Name – please print**

GOOD BEGINNINGS NOTIFICATION OF FEES

FOR CAREFIRST/BCBS and KAISER CLIENTS

Occupational Therapy: The cost of a 90-minute occupational therapy evaluation is $826.25*. The evaluation includes testing and scoring. In the event there are multiple areas of concern, extended evaluation time may be required and will be billed in 15-minute increments. A written report will also be provided.

Physical Therapy: The cost of a complete 60-minute 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*

January 2019

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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. **It is most time efficient to communicate directly with your therapist vs. through the front office for cancellations and reschedules; please coordinate with your therapist on the best method for the both of you.**

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

______ For reserved, weekly, appointments, cancellations with notification less than 4 hours (for any reason) will be charged a late cancellation fee of $72.50*. Any/all missed appointments without notice to your therapist will be considered a No-Show and your account will be assessed a fee of $145*. 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. All cancellation and No-Show fees will be billed directly to you.

______ We schedule reserved appointments with start and stop times. We reserve the right to charge you directly for any missed portion of a therapy session (i.e. late arrivals, leaving early) as this time cannot be billed to your insurance company. These instances will be billed at $36.25 per 15 minute increments.

______ 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 cannot commit to a reserved or regular appointment schedule, or are having trouble with your current time slot, please contact our office for alternative scheduling options at 703.536.1817, ext. 100.

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.**

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 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. Children who arrive with visible symptoms/concerns will be sent home and rescheduled.

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

NAME: ____ FOR: ____

SIGNATURE: ____ DATE: __________________

** Fees subject to change*

January 2019

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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.

Cell/mobile call or VM: ____

Cell/mobile for text: ____

Work phone: ____

Home phone: ____

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

January 2019

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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