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

G·O·O·D BEGINNINGS

6231 Leesburg Pike, Suite 500
Falls Church, VA 22044

150 Elden Street, Suite 270
Herndon VA 20170

A Therapeutic Approach To

Movement & Learning

PATIENT DEMOGRAPHIC INFORMATION

CHILD'S NAME: _____ GENDER: M / F DATE OF BIRTH: ___/___/_____

CHILD'S DIAGNOSIS: _____

ALLERGIES/PRECAUTIONS: _____

*PEDIATRICIAN/PRIMARY CARE PRACTICE:*_____

*PRIMARY PHYSICIAN SEEN:*_____

*PHONE NUMBER:*_____

*ADDRESS:*_____

PARENT/GUARDIAN NAME:_____ DATE OF BIRTH:___/___/___

ADDRESS:_____

PARENT/GUARDIAN NAME:_____ DATE OF BIRTH:___/___/___

ADDRESS:_____

CONTACT INFORMATION: Primary phone (incl. name): _____ Mobile / Home / Work
Secondary phone (incl. name): _____ Mobile / Home / Work
Primary email: _____
(We will NOT share this information with anyone outside of Good Beginnings.)

Emergency contact/relationship: _____ Mobile / Home / Work

HOW DID YOU HEAR ABOUT US?_____

INSURANCE COMPANY: _____DATE OF BIRTH: ___/___/___

INSURED'S NAME: _____

INSURED'S EMPLOYER: _____

ID #: _____ Group #: _____

PHONE NUMBER:_____

CLAIMS ADDRESS: _____ _____

INSURED'S SOCIAL SECURITY #: _____

TODAY'S DATE: ___/___/___

***For office use only*:** ICD-10: Code 1_____ Code 2_____ Code 3_____

Please Circle: OT or PT December 2019

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PATIENT HISTORY - PT and OT (page 1 of 2)

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

Birth History *(Please circle for yes and draw a line through for no. Complete to the best of your memory):*
Gestational Age: _____ Mom on Bedrest Birth weight:_____
Vaginal delivery or C-section Forceps or vacuum extraction used Jaundice
Required Oxygen Time in NICU Sucking/swallowing problems
Adoption (please list when/age) Surgery (please list): _____

Medical History *(Please circle for yes and draw a line through for no. Include surgeries &/or illnesses. Complete to the best of your memory):*
Reflux Feeding difficulties Ear infections-more than 3 Ear tube placement
Cranial orthosis Hearing loss Seizures Gastric Reflux Allergies

Current height and weight percentiles:
Current Medications & Allergies:
Other medical specialists seen:

Family History:
Who are the members of your immediate family & caregivers?_____
Are siblings developing typically? YES / NO Any pertinent family medical history?_____
_____

Developmental History: please list the age (when applicable) that your child began:
Holding head up in tummy time: Rolling back → tummy:
Sit independently: Crawl:
Take first steps: Self-feed finger foods:

School/Daycare:
Does your child attend daycare? Yes / No
Does your child attend school? Yes / No Name of school/grade? _____
Does your child receive PT/OT/speech via school or early intervention? _____
Do you have a current IFSP/IEP/504? Yes / No

*****What do you hope to achieve with/for your child at Good Beginnings?*****

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PATIENT HISTORY – Please continue if seeing OT (page 2 of 2)

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 and for Good Beginnings to act as my agent in obtaining payment from my insurance company.

___ ___ 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 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

Good Beginnings requires a credit card on file in order to schedule an appointment and to auto charge any remaining balances not covered by your insurance company. Any credit cards kept on file will be kept in a secure vault. A receipt will be emailed to the parent email on file when the credit card on file is used.

Co-payments are due at the time of service. We accept cash (exact amount) and check in the office or you can use your credit card to pay online at www.gbtherapy.org/pay-your-bill. Online payments are subject to a 2% processing fee. We are unable to accept credit card payments in the clinic. Co-payments not paid at the time of service will be automatically charged to the card on file upon receiving notice from your insurance company and are subject to a 4% processing fee.

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

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.

INSURANCE BILLING: As a courtesy, we will submit claims 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. Good Beginnings will invoice you after your insurance company has paid if there is any remaining patient portion.

Balances not paid 30 days from invoice date will be automatically charged to the card on file and be subject to a 4% processing fee.

You are responsible for checking benefits and any terms related to specific coverage policies.

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).

Good Beginnings **does 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.

Good Beginnings will perform an Annual Plan of Care review. This can be billed to your insurance company and count towards one of your visits. If you wish to pay for this out of pocket and not billed as one of your visits you may privately pay.

Additional reports/form completion/extra documentation or phone calls/emails 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.

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.

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

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.

Good Beginnings may suspend therapy sessions for any patient balances exceeding $500.00 or at their discretion. Our Billing Department 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 acknowledge that I am solely responsible for any balance not paid by my insurance company. 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	**Date**	**Child's Name – please print**

January 2020

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ATTENDANCE/CANCELLATION POLICY

Regular attendance is essential for your child's growth in therapy. We have an online appointment request system to facilitate rescheduling of appointments at https://app.practiceperfectemr.com/booking/goodbeginnings. Although we encourage rescheduling, we cannot guarantee your therapist will have availability. If your therapist does not have an available slot for you to rebook into, you will be charged for the cancelation as noted below. The system gives you real time options with 24 hour access.

Good Beginnings charges a $35.00* cancellation fee for all cancelled appointments. The first cancellation of the year is waived (for each therapy discipline), further cancellations will be assessed the $35.00 cancellation fee. The cancellation fee will be waived if you are able to reschedule via the online appointment request system by the close of business the day you were scheduled. All missed appointments without notice to your therapist, will be assessed a $150.00* No Show fee.

Good Beginnings reserves the right to deny ongoing therapy 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 complete all necessary procedures.

Good Beginnings is closed on the following holidays: New Year's Day, Memorial Day, July 4th, Thanksgiving Day & 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), to discuss.**

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. If your therapist thinks that your child is sick and/or contagious, he or she will be sent home and charged a cancelation fee. 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. For time sensitive issues, please refer to your "Common Questions/Friendly Reminders" handout for the best way to contact your therapist.

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*

January 2020

GOOD BEGINNINGS NOTIFICATION OF FEES

FOR CAREFIRST/BCBS and KAISER CLIENTS

Occupational Therapy: The cost of a 90-minute occupational therapy evaluation is $825.00*. 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 $325.00*. 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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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

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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