carolina Pediatric Therapy

Physical, Occupational, Speech Therapy
Early Childhood Intervention
Audiology & Behavioral Health

We are so glad that you have chosen the Carolina Pediatric Therapy team to provide therapy services for your child. We want you and your child's therapy experience to be an excellent one. We feel that you are an equal member of your child's therapy team, and value your input into your child's treatment program. In fact, we will ask for your input often.

We know that the best results come when every person in the child's environment and daily routine is aware of their goals, and actively participates and supports the child as he or she works on specific skills. This means that we may ask you to work with your child on certain skills between our therapy sessions.

While each therapy discipline focuses on specific skills, we strive to provide treatment to your child from a whole-child perspective. We realize that several factors can influence how well a child does in therapy, and we always take those things into consideration when planning your child's treatment. Please let us know how we can help to support you and your child through their learning, growth, and development!

We look forward to our journey together as we work to help your child be successful and meet his or her goals! We are excited to be able to celebrate along with you, each gain that your child makes! Thank you again for entrusting your child's therapy experience to our team!

Check out our online articles on child development and other topics at
www.CarolinaPeds.com

Patient Information

Patient Last Name:	First:	Middle MI:	Birth Date:	Age:	Gender:
			/ /		M ☐ F ☐

Address		
City	State	Zip

Primary Care Physician:	Referred By:	Dominant Hand
		L ☐ R ☐

Asheville Clinic
9 W Summit Avenue
Asheville, NC 28803
828 670 8056

Brevard Clinic
159 King Street, Suite B
Brevard, NC 28712
828 670 8056

Hendersonville Clinic
510 Fleming Street, Suite A
Hendersonville, NC 28739
828 393 5902

Parent or Legal Guardian Informed Consent for Services

I consent for my child to receive evaluation and/or therapy services from Carolina Pediatric Therapy and their treating therapists according to my child's physician's orders. I understand that Carolina Pediatric Therapy will bill my insurance company first. If the service is not covered by my insurance, I agree to pay for the service in-full immediately upon receiving a bill from Carolina Pediatric Therapy. If my child has NC Medicaid, CPT will accept the reimbursement as payment in full. I also understand that it my responsibility to keep my child's insurance and/or Medicaid coverage in effect. I agree to inform CPT of any changes in my child's insurance coverage. I understand that if I do not keep my insurance or Medicaid coverage in effect, and do not inform CPT, I agree to pay the usual and customary fee for services provided during the period without coverage. If the above named child needs emergency medical care while receiving services, I give permission for Carolina Pediatric Therapy or their treating therapists, to obtain such care, and I agree to be financially responsible for the services.

Print Child's Name

Child's Date of Birth

Parent or Legal Guardian Signature

Date

Direct Assignment of Insurance Payment

Please bill my **insurance**: When Carolina Pediatric Therapy files for third party insurance payment under my policy benefits, and they are otherwise payable to me as the policyholder, I authorize payment directly to Carolina Pediatric Therapy. If my policy prohibits direct payment to a doctor or treatment facility, the payment should be made to me as the policyholder, and I agree to reimburse the full amount to Carolina Pediatric Therapy. This is a direct assignment of rights and benefits under my insurance policy. Further, I agree to pay to Carolina Pediatric Therapy, in a timely manner, any balance that remains after payment of insurance benefits. A photocopy of this assignment shall be considered as effective as the original.

I have read and understand all of the above, and I agree to all of the conditions and information. I understand that this agreement will remain in effect the duration of treatment, and that I can revoke this agreement at any time in writing, except for services that have already been provided.

Policyholder/Legal Guardian Responsible for Payment

Date

Please bill me **directly**: *(Sign the following section ONLY if you wish to be personally billed for services; otherwise, leave blank.)*
I request that I, in accordance with the Health Insurance Portability and Accountability of 1996 ("HIPPA"), 45CFR 164.522 that Carolina Pediatric Therapy NOT contact my insurance carrier. In doing so, I understand the policy benefits will not apply to my charge for services and that I WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICES. PLEASE BILL ME PERSONALLY AT THE TIME THAT SERVICES ARE RENDERED.

Policyholder/Legal Guardian Responsible for Payment

Date

Release of Information

I authorize Carolina Pediatric Therapy, and/or their treating therapists to obtain/release information, as necessary, for the purpose of filing for insurance compensation or for requesting compensation from Federal or State resources that appropriate payment for services my child receives. I understand that in order for my child to be provided with the best possible services, CPT must have my permission to communicate with other providers involved in my child's care. I hereby grant permission for CPT and their treating therapists to obtain/share information with the following agencies/persons:(Please list the names of all physicians, practices, and agencies that are involved in your child's care)

Primary Physician/practice name

Other Current Service Providers

Physicians/Specialist

Children's Developmental Services Agency (indicate which office)

Daycare

Preschool Program

School System

Previous Providers

Parent or Legal Guardian Signature

Date

Acknowledgement of Privacy Notice, Client Privacy Rights, & Parent Manual

As a client of CPT, you have certain rights regarding your child's services and the protection of you/your child's health care information. "Notice of Privacy Practices and Client Privacy Rights" has been given to you today.

I have received a copy of the "Notice of Privacy Practices" and its contents have been explained to me in a manner in which I understand.

Parent or Legal Guardian Signature

Date

Carolina Pediatric Therapy's Notice of Privacy Practices & Client Privacy Rights

Our Pledge to You: We understand that your child's heath information is personal and we are committed to protecting it. We create a record of the care and services your child receives at our organization. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about your child, describes your rights, and our duties regarding the use and disclosure of this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, the Confidentiality Law, 42 CFR Part 2, and the NC General Statutes 122c protect your child's healthcare information.

Under these Laws:

1. Our staff cannot acknowledge their professional relationship with you or your child to any person, including your family and friends, without your written authorization or one of the exceptions listed below.
2. We may not disclose any information identifying your child as a client, except as permitted by law.
3. We must obtain your written consent before we can disclose information to your health insurer/Medicaid in order to be paid for your child's services. If you do not authorize us to release information to your insurance company, then full payment will be required at the time of service.
4. We may use and disclose your protected health information for health care operations:
    a. Our office staff, clinical staff, and case managers are authorized to review medical records for the purpose of providing client care and treatment.
    b. Support staff and billing staff are authorized to review protected health information for the purposes of carrying out their routine jobs;
    c. Staff members conducting quality assurance, utilization review, and peer review activities may access protected health care information when they perform their review responsibilities.
    d. Students, interns, and trainees who have signed a confidentiality agreement with us and are working with CPT staff members to help them practice and improve their skills may also access information.

When law requires the use and/or disclosure.

1. When it is necessary for public health activities;
2. We may share information with a physician who referred you to our agency.
3. We may share information with a business associate of CPT. (A business associate is one who provides services to CPT or provides services on our behalf.)
4. For research, audit, or evaluations,
5. To report a crime committed against our personnel;
6. To medical personnel in a medical emergency;
7. If we believe you are a danger to yourself or to others, or if we believe that you are likely to commit a crime, we may share information with law enforcement.
8. To appropriate authorities to report suspected abuse or neglect.
9. As allowed by court of law.

Written Authorization for Disclosure of Information
Before we can use or disclose any information about your health in a manner that is not described above or in items 1-10, we must first obtain your specific written authorization allowing us to make the disclosure. You may revoke any such written authorization in writing except for action has already been taken.

Contact From Our Office/Your Child's Therapist
We may contact you to provide appointment reminders, billing clarifications, assess the quality of our services, or other health-related benefits and services that may be of interest to you. If you choose not to be contacted by us via telephone, letters, or messages, document your objection in writing, and give it to your service provider.

Our Duties
We are required by law to maintain the privacy or your child's health information, to provide you with a notice of our legal duties and privacy practices with respect to your child's health information, and to abide by this notice. If there are any changes made to the terms of this notice, we will provide you with the changes in writing. All CPT staff has been trained in maintaining your confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996("HIPPA").

Client Privacy Rights

1. Under HIPAA, you have the right to request restriction on certain uses and disclosures of your health information. CPT is not required to agree to any restriction you request, but if we do agree, then we are bound by that agreement and my not use or disclose any information for which you have restricted, except as necessary in a medical emergency or as required by law.
2. You have the right to request that we communicate with you by alternative means or at an alternative location. We will accommodate such requests that are reasonable and will not request an explanation from you. For example: you may wish for us to call you at a different telephone number.
3. You have the right to inspect your record. Inspections must be scheduled with your primary provider and in some circumstances, requests may be denied. You also have a right to request a personal copy of your record for a fee. Carolina Pediatric Therapy must respond to your request within 30 days.
4. You have the right, with some exceptions, to amend healthcare information maintained in our records. All requests for amendments must be made in writing. Carolina Pediatric Therapy must respond to your request within 60 days.
5. You have the right to request and receive an accounting of disclosures of your health-related information made by CPT during the six years prior to your request (Not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following for your treatment, for billing and collection of payment for your treatment, for our health care operations, made to or requested by you or that you authorized, occurring as a result of permitted uses and disclosures, made to individuals involved in your care, allowed by law or if the information released did not identify you.
6. You have the right to receive a paper copy of this notice.

Client Grievances

CPT provides a policy regarding client grievances and complaints: If you have a grievance that cannot be resolved with your therapist, you should document your grievance and forward it to Carolina Pediatric Therapy, Attn: Summer McMurry, 9 W Summit Avenue, Asheville, NC 28803. You may file a complaint with CPT and/or the Secretary of the United States Department of Health and Human Services if you feel that your privacy rights have been violated under HIPAA. If you file a complaint, we will not take any action against you or change our treatment of you in any way. To file a complaint with Carolina Pediatric Therapy, document your complaint in writing along with your full name, address, and phone number and forward it to our privacy officer.

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Authorization for Disclosure

Client Last Name, First, & Middle | DOB | Medical ID# | Record#

I, _____ , authorize Carolina Pediatric Therapy to release personal health information (PHI) reciprocal to and from from:

Title/Designee

Address | City | State | Zip

Agency Receiving Info | Phone | Fax

Information to be released: ____ Verbally ____ In Writing ____ By Fax ____ by encrypted email

Protected Health Information to be Released to CPT:

__ Birth Medical Records, Child
__ Medical History, Exam, Physical and Treatment
__ Evaluation Report(s)
__ Treatment/Intervention Plan and/or Progress Notes
__ Client Contact Activity Notes
__ Other (specify): _____

Protected health Information to be Released by CPT:

__ Evaluation Report(s)
__ Treatment/Intervention Plan and/or Progress Notes
__ Client Contact Activity Notes
__ Insurance/Financial Information
__ Other (specify): _____

Specific Purpose of Disclosure to CPT:

__ Assessment, Planning and Coordination of Developmental, Medical and Educational Services
__ Coordination of Client Care
__ Referral for additional Medical, Developmental, Educational, Specialized Therapy or Social Services
__ Other (specify): _____

Specific Purpose for Disclosure by CPT:

__ Assessment, Planning and Coordination of Development, Medical and Educational Services
__ Coordination of Client Care
__ Referral for additional Medical, Developmental, Educational, Specialized Therapy or Social Services
__ Other (specify): _____

Client Rights: I understand that if my record contains information relating to HIV infection, AIDS or AIDS related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing this disclosure will include that information (per NCGS-130A-143 & 42CFR Part 2) The confidentiality of those records are protected by regulations (APSM 45-2 State Confidentiality Rules) which prohibit anyone from further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

_____ I agree that this information may be disclosed **_____ I do not agree that this information may be disclosed**

A readable photocopy of this authorization shall have the same force and effects as the original. I may ask for and get a copy of this authorization. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain evaluation, treatment, payment for services, or my eligibility for benefits. I understand that only health care providers, plans and clearinghouses must follow the federal privacy standards. If an individual or organization receiving my protected health information does not fall into one of these categories, this authorization ceases to be protected by the federal privacy standards therefore, allowing for possibility of my protected health information being re-disclosed without further authorization. I understand that I may cancel this authorization at any time by filling out the section labeled "Cancellation of Authorization" below. This cancellation is effective to the extent that action (e.g. released protected health information) has not already been taken.

This consent shall be valid until: _____ (This authorization is valid for 1 year from the date signed, unless a date, event, or condition is written in the blank provided.)

I have had an opportunity to review and understand the content of the authorization form. By signing this authorization, I am confirming that is accurately reflects my wishes.

Parent/Legal Guardian Signature | Date | Relationship to client: Parent, Guardian or Legal Representative

Consumer Signature (over the age of 18) | Date

Witness | Date

Cancellation of Authorization to Disclose PHI. I, _____ , cancel this authorization. I understand that Carolina Pediatric Therapy cannot undo any actions taken under this authorization after it was signed but before it was cancelled.

Signature | Date | Witness | Date

Cancellation & Attendance Policy

Asheville:	9 W Summit Avenue, Asheville, NC 28803	828.670.8056
Hendersonville:	510A Fleming Street, Hendersonville, NC 28739	828.393.5902
Brevard:	159 King Street, Suite B, Brevard, NC 28712	828.862.3282

At Carolina Pediatric Therapy, we desire to partner with you to promote your child's best possible progress. Consistent attendance during therapy is critical to promote a successful therapy program. We have developed this cancellation policy to:

- Ensure that all of our clients receive effective, timely, and appropriate service
- Protect the time, energies, and availability of our therapists
- Use both the caregiver and therapist's time most effectively for your child's therapeutic progress

Missed appointments and appointments cancelled in less than 24 hours of scheduled time impact our ability to provide effective therapy services to you and limit the availability of appointments for other clients. A pattern of missed appointments may result in us no longer being able to provide services for your child.

Cancellation

As a courtesy to our therapists and other clients, please contact the clinic or your therapist at least 24 hours prior to your appointment time to cancel.

Three cancellations may result in the loss of your appointment time.

If attendance falls below 80% over a 3 month time period, your appointment time may be in jeopardy. Chronic cancellations decrease a child's expected progress in therapy.

Cancellation with less than 24 hours notice due to non-emergency = **$25** fee

No Show

Failure to contact the clinic or your therapist to report a cancellation is considered a 'no show'. Three no show appointments will result in dismissal from your current therapy and your child will be placed back on the waiting list for services.

No call/no show = **$25** fee.

To cancel your therapy session, please contact your clinician or the clinic at (828) 670-8056 or email at info@CarolinaPeds.com

By signing this form, I agree to cooperate with the cancellation, attendance, and scheduling policy of Carolina Pediatric Therapy and its treating therapist.

Signature of Parent or Authorized Person

Date

Financial Agreement & Policy

Insurance Participation
We have contracts with and file claims for most major insurance companies including Medicaid. It is the responsibility of the patient, parent, or caregiver to see if we are in network with your particular insurance as well as to ensure your particular service is covered.

Assignment of Benefits
I hereby assign all medical and therapy related benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Carolina Pediatric Therapy rendered to myself and/or dependents regardless of my insurance benefits, if any, I understand that I am responsible for any amount not covered by insurance.

Eligibility Information
Our administrative team will attempt to access eligibility, co-pay, co-insurance, and deductible information. It is the responsibility of the patient, parent, or caregiver to contact Carolina Pediatric Therapy if there are questions regarding this information. We encourage each family to call and find out their specific benefits for their policy. It is the responsibility of each patient to understand his or her own insurance coverage.

Filing Insurance
Carolina Pediatric Therapy will file claims for insurances for which we are in network and secondary insurance. We accept the contractual write-off based on your primary insurance. After we have received payment information from your insurance, you will be billed for any outstanding balances.

Keep us in the loop
Errors in billing and claims payment are often the result of incorrect information. Please keep us informed and up to date with the correct name, address, email address, phone number, primary care information, and insurance changes.

Payment
We accept check, cash, visa, MasterCard, and Carecredit. You may make payments online at our website www.carolinapeds.com

Self Pay Discount
We do offer a self-pay discount if you do not have insurance to file. Timely payment is expected. We do not allow patients who have insurance to use the self-pay discount.

Co-Payments
Many plans require a co-payment for each visit. We are contractually bound by insurance companies to collect co-payments for services rendered. If your treatment occurs in clinic, we will require payment at the time of service. If your therapy service is provided at home, daycare, or other non-clinic location, we will add the co-payment to your monthly invoice, or can set up credit/debit card payments to collect co-payments at the time of service.

Late Fee
We will charge a 5% late fee for all balances over 30 days.

Patient Refunds
Refunds will be reviewed on a per claim basis. Upon confirmation and approval of refund, a check will be issued to the account holder.

Returned Check Fee
Carolina Pediatric Therapy charges a $25 returned check fee.

Delinquent Accounts
We will attempt to contact you by phone and mail regarding delinquent accounts. Failure to make payment will result in suspension of treatment and the account being released to our contracted collection agency.

Custody/Payment Issues
Due to the many complicated issues that arise due to custody and payment issues, it is office policy that payment is expected by whichever parent is bringing the child to treatment sessions. Parents may then work out agreement for repayment among themselves.

No-Show/ Cancellations
Please give our therapist at least 24 hours advanced notice of cancellation so that we may attempt to offer the cancelled appointment to another client. Cancellations with less then 24 hours notice is subject to a $25 cancellation fee unless the cancel is due to illness or emergency.

No-show's will result in a $25 cancellation fee.
If a patient has 3 no-shows or cancellations without 24-hour notice, therapy services may be suspended or terminated.

Inappropriate Behavior
CPT strictly prohibits verbal or physical abuse of any kind to our therapist and staff. Inappropriate behavior will result in termination from therapy services.

By signing this form, I agree to cooperate with the Financial Agreement and Policy of Carolina Pediatric Therapy and its treating therapists.

Signature of Parent or Authorized Person

Date