619 A East King Street
King, North Carolina 27021
336-608-0555

PERSONAL INFORMATION
Child's Legal Name: _____Date of Birth:_____ Age:____
(check one) Male: __ Female: __
Address:_____
Medical ID Number: _____
Parent or Legal Guardian Name_____
Phone Number:_____ Ok to leave a message: Yes No
If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person._____
EMERGENCY CONTACT: NAME: _____ PHONE: _____
RELATIONSHIP: _____
Physician name:_____ Physician phone number:_____
Physician fax number:_____

INSURANCE INFORMATION (please fill out ALL areas)
Insurance Name:_____ Insurance Phone Number: _____
Insured's DOB: _____ Policy Number: _____
Group Number: _____ Claims Address: _____
Secondary Insurance:
Insurance Name:_____ Insurance Phone Number: _____
Insured's DOB: _____ Policy Number: _____
Group Number: _____ Claims Address: _____

I DO NOT YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. IF MY BENEFITS CHANGE OR ARE DISCONTINUED I WILL NOTIFY COTS PRIOR TO ANY SERVICES OR BE CHARGED $100 PER VISIT FEE FOR ANY SERVICES RENDERED Initial _____

Emergency Medical Release In the event medical attention is required for your child while the premises of Carolina Occupational Therapy Services (COTS), we need your authorization to implement treatment. Please read and sign statement below.
As a parent/legal guardian of _____, I give my permission for Carolina Occupational Therapy Services (COTS) to contact emergency personnel in the event of a medical emergency.

Parent/Legal Guardian Signature _____Date_____

MEDICATION/ALLERGY/CONDITION FORM
Diagnosis and medical history: Please indicate any medical diagnosis or medical condition, with dates if known.

_____
_____
_____
_____
_____

Medication: Please include prescription drugs, over the counter medications, vitamins, and homeopathic medications.

_____
_____

Allergies/Reactions:

_____
_____

AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS: Please initial the following statements:

_____ I have a prescription from my child's physician to authorize initial evaluation.

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.

_____I hereby give permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and COTS staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ I give Carolina Occupational Therapy Services (COTS) permission to submit bills directly to the insurance carrier.

_____ I have read and agree to follow Carolina Occupational Therapy Services (COTS) office and financial policies.

_____ _____

Signature of Parent/Guardian Date

General History

1. When did you first become concerned about your child's development?

_____
_____
_____

2. Has your child received occupational, physical, or speech therapy in the past or is he/she currently receiving any of these services? (Please list providers and days/times if currently received and describe):

_____
_____
_____

3. School Therapy (Name of school, therapist name and number, and day of week they receive services, bring copy of
IEP)_____
_____

***If your child is receiving services through another agency, for billing purposes, we cannot duplicate services on the same day so please be aware of child's schedule and let us know**

those days in advance. Failure to do so, will result in personal pay charges for that day. (initials)_____

Medical History

1. Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:_____
_____

2. Was your child premature? Yes or No

3. Born at how many weeks gestation?_____ Birth Weight_____

4. Did your child require any medical procedures before, during, or after birth? Please describe:
_____
_____

*FEEDING*Did your child have any feeding problems as an infant? Please describe:
_____
_____

*HEARING*Do you have any hearing concerns? If yes, describe.
_____
_____

Has your child had their hearing tested? What were the results?
_____
_____

OTHER

Does your child wear glasses or hearing aids? If yes, why?_____
_____

List the names of the programs and people that have worked or are working with your child outside of COTS.

Service Program:	Name Teacher/Therapist	Phone #	Dates
Pediatrician/Physician:			
Child Care Program:			
Preschool:			
School:			
Occupational Therapist:			
Speech Therapist:			
Physical Therapist:			
Counselor/Psychologist:			
Infant Learning Program:			
Head Start Program:			
Caseworker/Care Coordinator:			
Dietitian/Nutritionist:			
Specialty Doctor:			
Other:			

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication to COTS.

_____ _____

Signature of Parent or Guardian Date

PATIENT AGREEMENT

Carolina Occupational Therapy Services (COTS) offers Occupational Therapy services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your child's therapy needs. We will also work with your primary care practitioner to coordinate your care.

Following the initial assessment visit(s), we develop a specific plan of care (POC) for review and approval by your child's referring provider. Once your child's referring provider signs the (POC), we can begin working with your family to improve your child's condition. We are pleased to serve your Occupational Therapy needs and encourage your feedback to alert us to anything we can do to provide your child the highest quality of care.

We require certain information from each patient in order to begin providing care. The attached forms need to be completed in order for us to begin serving your child as our patient. Please do your best to complete all the information. If certain information does not apply to your child, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payor has different guidelines for allowing coverage of Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services. It is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are needed. If your child is a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payor does not cover Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

North Carolina requires that a physician, physician assistant, or advanced nurse practitioner refer you to our practice before we can perform an initial assessment on you. After we have completed your initial assessment, we develop an individualized POC to meet your specific therapy goals. Your primary care practitioner will need to review and approve your POC, and then return it to our practice before we can begin your treatment.

MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE

Private insurance companies may have limits on the amount of Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services covered. Once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of your child's services. Additionally, private healthcare insurance payors have deductible and co-payments for physical therapy, occupational therapy, and/or speech language pathology services that are the responsibility of the patient.

While this practice will not discontinue your child's services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements.

COLLECTION OF PAST DUE ACCOUNTS We communicate with our patients' parents/guardians to resolve past due accounts in all cases. If we cannot reach a patient's parent/guardian by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT New patients approved for Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services are responsible for any and all charges not paid for by healthcare insurance payors (Medicaid, private health insurance carriers, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Carolina Occupational Therapy Services for the services we provide to you, our valued customer. Following the receipt of your monthly patient statement, please contact our practice to make payment arrangements. We accept cash or personal checks; we also make credit card pre-payment

arrangements for anticipated monthly patient balances. We also are willing to make reasonable payment arrangements to keep your account current. Please contact our Billing Office at (336) 608-0555.

PATIENT STATEMENT OF AGREEMENT My signature below signifies that I have read and understand this patient agreement for Carolina Occupational Therapy Services to provide me Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

_____ _____

Parent/Legal Guardian Date

CANCELLATION POLICY

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your therapist and the front desk administrator. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime. This will allow other patients in need of care to be accommodated as we have many patients. It is both unfair to the other patients and therapists to not allow for others to schedule in the open time slots. ☐ I understand it is my responsibility to communicate to the front desk. Any schedule changes or appointment cancellations. _____ initials

**If a session is delayed for more than 10 minutes due to late arrival of the client, the parent(s)/guardian will be charged a $10.00 late fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian. _____ initials

**If a parent/guardian is more than 5 minutes late to pick their child up, the parent(s)/guardian will be charged $1 for every minute they are late. (e.g., You will be charged $6 on the 6th minute of being late, etc.) This is to ensure that parents are present so the therapist can collaborate with the parent(s)/guardian and other children's sessions can start on time. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian. _____ initials

**If a therapy session is not cancelled prior to an appointment time or is missed without any notice, this missed appointment is counted as a no-show which will result in a charge of a $50.00 no-show fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian. _____ initials

**Two consecutive no-shows may require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on our information list. ____ initials

**We require an 80% attendance rate and may need to remove the patient from the therapist's schedule if efforts are not made to maintain this rate. Note: We track visit frequently and, as a courtesy, will notify you if your percentage drops below the required 80%. _____ initials. We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, (such as for an extended trip), we will hold your therapy spot for up to three weeks. We will then place you on the information list and will fit you back in the schedule as soon as we can. I hereby understand the above cancellation policy and agree to abide by it.

_____ _____

Parent or Guardian Signature Date

I have received and reviewed a copy of the (HIPAA) Health Insurance Portability and Accountability Act of 1996 (see below).

_____ _____

Parent/ Guardian Signature Date

Notification of HIPPA policies

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION [45 CFR 164.520] Background The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights. How the Rule Works General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices. The Privacy Rule does not require the following covered entities to develop a notice: C Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1). C A correctional institution that is a covered entity (e.g., that has a covered health care provider component). C A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information. See 45 CFR 164.520(a). Content of the Notice. Covered entities are required to provide a notice in plain language that describes: 1 How the covered entity may use and disclose protected health information about an individual. C The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity. C The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information. C Whom individuals can contact for further information about the covered entity's privacy policies. The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice. A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals. Providing the Notice. C A covered entity must make its notice available to any person who asks for it. C A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits. C Health Plans must also: < Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment. < Provide a revised notice to individuals then covered by the plan within 60 days of a material revision. < Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years. C Covered Direct Treatment Providers must also: 2 Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained. < When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice. < In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals. < Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility. C A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice. See 45 CFR 164.520(c) for the specific requirements for providing the notice. Organizational Options. C Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible. C Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service 3 delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).