



Dear Families:

Thank you for choosing KIDS CAN DO to provide pediatric therapy services. You can expect our maximum efforts in providing quality intervention for your child.

Please take a moment to complete the attached forms. The client information sheet and developmental history form will give us some basic information about your child. Additional information that you feel will be useful for therapeutic programming is always welcome. Included is a Notice of Patient Information Practices and Patient Information and Treatment Consent Forms which **MUST** be returned before services can be initiated. Also, please review the enclosed financial policy. It is designed to keep you better informed regarding the status of your account and to give you a number of payment options to choose from in order to make your therapy payments as easy on you as we can. We require that each family complete an insurance benefits verification form and a patient information form. **(Please leave NO blank lines!)** A signed copy of our financial policy is **REQUIRED** to insure that families understand their financial responsibilities regarding payment for services. If these forms are not complete, we will mail charges directly to the parents.

Thank you again for choosing KIDS CAN DO. We look forward to working toward positive changes together.

Paula Hinds  
Director, Kids Can Do, Inc.

**KIDS CAN DO, INC. FINANCIAL POLICY**    Effective January, 2010

1. We require a signed copy of this financial policy before therapy services are performed.
2. We require certain co-payment or pre-payment amounts depending on the type of insurance and insurance carrier. You may use cash, check, credit card, or a pre-approved extended payment plan. **If a claim has not been paid by your insurance company within 90 days, we require that you pay the balance using one of the approved payment methods. If this 90-day balance is not paid, therapy services will be suspended until a payment plan is implemented by the billing department. Unpaid balances over 120 days without an approved payment plan are sent to collections. Unpaid balances over 120 days with an approved payment plan will be charged 1.2% interest per month on the monthly balance.**
3. It is the responsibility of the insured to contact the insurance company to determine if Kids Can Do, Inc. is a preferred provider under their specific plan. It is recommended that this be done on a regular basis, as preferred provider status changes frequently. Our tax ID# is 36-3594409.
4. A **25%** discount will be offered to all self-pay clients and clients with insurance coverage in which Kids Can Do is not a contracted provider who pay in full at the time services are rendered, by **cash or check** only. A **20%** discount will be offered for **credit card** payments at the time of service. This discount only applies if Kids Can Do, Inc. does **not** generate a claim and/or directly bill the insurance company for these paid services. An invoice will be provided at the time of service.
5. Co-payments may be expected to be paid at the time of service. For families with United Healthcare Insurance, a 50% payment will be required at the time of service. Please be prepared to pay this amount at the time that therapy is provided. Office personnel will be expecting payment following each treatment session and can issue a receipt for payment if requested.
6. We will send out claims for services on a weekly basis, as a courtesy for our clients. Please indicate whether you would like for us to do this. In addition, we will be responsible for ONE re-submittal to insurance; after that, **the client is responsible for denied payment**. We will continue to provide the necessary documentation required by the insurance carrier, so that the insured can continue to pursue payment at their discretion.

I request that my bills be sent directly to my insurance carrier. I have provided necessary claim forms and insurance information to Kids Can Do, and authorize payment to Kids Can Do, Inc. I authorize Kids Can Do, Inc. to release information to my insurance company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
- For self-pay clients and clients with insurance coverage in which Kids Can Do is not a contracted provider only:

I request that my bills be sent directly to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
7. Three absences per each scheduled weekly session are allowed per quarter (Jan.-March; April-June; July-Sept.; Oct.-Dec.) at no charge. Additional cancelled sessions will be billed directly to the client at **\$20.00** per scheduled session. **ALL NO-SHOW** appointments will immediately be billed to the family at a **\$50.00** charge. Please understand that our therapists reserve time specifically for your child, and are usually not able to reschedule that time. Insurance companies will not be billed for cancelled or missed sessions, and our bill will be sent directly to the family, for payment prior to the next treatment session. Lack of payment will result in a loss of your scheduled therapy time.
8. When cancellations are excessive (greater than 3 per quarter) for two quarters in a row, your child will lose his/her scheduled therapy time and will be offered home programming. The family may choose to place their child on our waiting list at that time or may choose to attend therapy at a facility that can accommodate high cancellations more easily.
9. Treatment sessions that involve more than one therapist result in charges for each therapist's time. For example, co-treatment by a speech therapist and an occupational therapist in an hour treatment session will generate two hours of billable treatment time.
10. We ask that families review benefit statements issued by their insurance companies which reflect payments made to Kids Can Do, to insure accuracy of billing and to keep current regarding benefit status of submitted claims.
11. Insurance plans that require a **referral** are the **responsibility of the insured (i.e. WellGroup, DSCC, MedCare Management, etc.)**. **Parents assume financial responsibility for treatment sessions their child attends that are not authorized for insurance coverage.**
12. A statement will be generated monthly to reflect activity on your account any time there is a patient balance due..
13. For children under 3 years old ONLY . We offer an administrative discount for clients birth to three years old, unless your insurance carrier prohibits such a discount. Please contact our billing department if interested in this discount.

**I HAVE READ AND AGREE TO THE TERMS OF KIDS CAN DO FINANCIAL POLICY.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Case History Form**

Date: \_\_\_\_\_

Child's name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip : \_\_\_\_\_

Mother's name: \_\_\_\_\_

Father's name: \_\_\_\_\_

Child's siblings/ages: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_

Father's work: (\_\_\_\_) \_\_\_\_\_

Mother's work: (\_\_\_\_) \_\_\_\_\_

Mother's Cell: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Father's Cell: (\_\_\_\_) \_\_\_\_\_

Emergency contact (other than parents)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

**Please list your child's physician and other specialists (name and specialty)**

1. \_\_\_\_\_

2. \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Prenatal and Birth History:**

Birth Weight: \_\_\_\_\_ Due Date: \_\_\_\_\_ Delivery Date: \_\_\_\_\_

Place of birth (hospital, city, state): \_\_\_\_\_

Please describe any health problems experienced by mother during pregnancy, delivery, or afterward: \_\_\_\_\_

Please describe any problems your child may have had during or after delivery: \_\_\_\_\_

**Relevant Medical History: Birth to Present (include medical testing & hospitalizations)**

| Dates/length of stay | Hospital/physician | Reason/treatment required |
|----------------------|--------------------|---------------------------|
| _____                | _____              | _____                     |
| _____                | _____              | _____                     |
| _____                | _____              | _____                     |
| _____                | _____              | _____                     |

**CURRENT MEDICAL STATUS**

**Please list all of your child's diagnosis or medical conditions:**

| Diagnosis | Date determined |
|-----------|-----------------|
| _____     | _____           |
| _____     | _____           |
| _____     | _____           |

**Please list any medications your child currently takes:**

| Medication | Reason | Frequency/dosage |
|------------|--------|------------------|
| _____      | _____  | _____            |
| _____      | _____  | _____            |

List any precautions or concerns we should be aware of relating to your child's medical status (including seizures or sensitivities): \_\_\_\_\_

Were your child's developmental milestones on target? \_\_\_\_\_ If no, please explain (continue on the back of this page): \_\_\_\_\_

**Please list any food allergies your child may have:** \_\_\_\_\_

**Has your child had a hearing test or screening?** \_\_\_\_\_ If yes, please give the age and results of the most recent exam: age \_\_\_\_\_ results: Passed/Deficit Found

**Does your child have a history of ear infections?** \_\_\_\_\_ If so, how many times? \_\_\_\_\_  
How were the ear infections treated? \_\_\_\_\_

**Has your child had a vision test or screening?** \_\_\_\_\_ If yes, please give the age and results of the most recent exam: age \_\_\_\_\_ results: Passed/Deficit Found

### **SCHOOL**

**Please give the name and address of the school that your child attends:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

**Does your child receive therapeutic intervention through school?** \_\_\_\_\_

**If yes, please list services and name(s) of those providing the service(s):**

| Service | Name  |
|---------|-------|
| _____   | _____ |
| _____   | _____ |
| _____   | _____ |
| _____   | _____ |

### **PARENT/CAREGIVER CONCERNS AND GOALS**

**Please state your chief concern leading to therapeutic assessment from this clinic:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list goals that you feel would enhance your child's independence:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**INSURANCE BENEFITS VERIFICATION FORM**  
**EFFECTIVE DATE** \_\_\_\_\_

Responsible Party Information

**PRIMARY COVERAGE**

Child's Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_

Insured's Marital Status: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_

Employer's Phone Number: \_\_\_\_\_

Insured's Occupation: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

\_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

I.D.#: \_\_\_\_\_ Group Policy Number: \_\_\_\_\_

**SECONDARY COVERAGE**

Child's Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_\_

Insured's Marital Status: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_

Employer's Phone Number: \_\_\_\_\_

Insured's Occupation: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

\_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

I.D.#: \_\_\_\_\_ Group Policy Number: \_\_\_\_\_



Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

\_\_\_\_\_ I give my consent to use video and still photography as an additional means of documenting and measuring my child's progress.

\_\_\_\_\_ I give my consent for my child's picture to be displayed in the waiting room. I understand that my child's picture will **not** be used for publicity or general publication without my consent.

\_\_\_\_\_ I give my consent for my child's picture to be used for educational, marketing purposes, and/or on the Kids Can Do, Inc website ([www.kidscando.org](http://www.kidscando.org)).

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

***Kids Can Do, Inc.***

**DRESSING AND BATHROOM PERMISSION FORM**

Dear Parent/Guardian(s),

Often times during therapy, it becomes necessary to have a child undress, whether it be to work on specific dressing goals, allow for the use of therapeutic modalities or orthoses, or assess posture and alignment. We are committed to maintaining your child's privacy during this process and will notify you if removal of clothing is needed in working to achieve your child's treatment goals. Undressing may also be necessary if your child needs assistance when using the bathroom during a therapy session.

We remind you that you are always welcome to attend or view any part of your child's treatment session.

Please read the statements below and check as appropriate.

\_\_\_\_\_ I give permission to my child's therapist(s) to assist my child in removing his/her outer clothing as needed to work on specific therapy goals.

\_\_\_\_\_ I give permission to my child's therapist(s) to cover the windows and one-way observation windows in a private room during dressing/undressing to increase the privacy for my child.

\_\_\_\_\_ My child is able to use the bathroom independently and does not need assistance.

\_\_\_\_\_ I give my permission to my child's therapist to assist my child in the bathroom should my child need assistance and I am not available.

\_\_\_\_\_ I do not want my child's therapist to assist my child in the bathroom should my child need assistance during therapy. I understand that I must remain onsite during all scheduled treatment sessions should I be needed to assist my child in the bathroom. If I am not on site, I understand that the therapist will assist my child in the bathroom as needed.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Kids Can Do, Inc.***

**DESIGNATED INDIVIDUALS AUTHORIZATION FORM**

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding this patient's treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees: (examples: school therapist, neurologist, psychologist, teacher)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

*Ref: P/P 1-10*

# ***Kids Can Do, Inc.***

## **NOTICE OF POLICIES AND PATIENT INFORMATION PRACTICES**

THIS NOTICE DESCRIBES OUR FINANCIAL POLICY, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW THE FOLLOWING INFORMATION CAREFULLY AND SIGN THE ATTACHED FORM.

### **Financial Policy Information**

***Kids Can Do, Inc.*** submits computer generated paper claims for billing of the services provided. Providing you have verifiable insurance benefits, you will not be required to pay at the time service is rendered. Claims will be filed directly with your insurance carrier unless your signature on our financial policy sheet (attached) indicates otherwise. Once your insurance has processed your claims you will be billed and required to pay for all co-pay, co-insurance, deductible and/or any other amounts not paid by your insurance carrier. We accept cash, personal checks, Visa or MasterCard.

### **Informed Consent Statement**

As a client or guardian of a client at Kids Can Do, Inc., I understand that the referral to this clinic may be based upon a combination of criteria including but not limited to my or my child's specific diagnosis, insurance carrier, location, credentials, personal reference or personal choice.

I understand that the course of treatment at Kids Can Do, Inc. is determined by a combination of factors including but not limited to specific diagnoses, physical demands/environment, medical history, athletic involvement and personal needs. I accept the program of treatment will be determined as a joint effort by my referring physician and by the results of the evaluation which is performed by the therapist. I expect that the treatment will be fully explained to me as well as the pertinence of this treatment to the specific need(s) which may be present at the time of the evaluation.

I additionally understand that my questioning of any treatment while under the care of Kids Can Do, Inc. by no means challenges the abilities or qualifications of the therapist and does not lessen my commitment to my full cooperation of the therapy program.

I also understand that in the course of treatment at Kids Can Do, Inc., I have the right to refuse, at any time, a treatment or treatments which I feel may not suit my or my child's needs or personal preference and that this right will supersede the recommendation of my physician, primary therapist, or insurance carrier.

### **Kids Can Do, Inc.'s Legal Duty**

***Kids Can Do, Inc.*** is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

***Kids Can Do, Inc.*** uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ***Kids Can Do, Inc.*** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

**Kids Can Do, Inc.** may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, **Kids Can Do, Inc.** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

**Kids Can Do, Inc.** may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

## **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Kids Can Do, Inc.** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

## **CONCERNS AND COMPLAINTS**

If you are concerned that **Kids Can Do, Inc.** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Kids Can Do, Inc.'s** health information practices or if you have a complaint, please contact the following person:

**Kids Can Do, Inc..**

**HIPAA OPERATIONS MANAGER**

**19100 S. Crescent Drive, Suite 101**

**Mokena, IL 60448**

**Telephone: 708/478-5400 Fax: 708/478-5300**

## PATIENT INFORMATION CONSENT FORM

I have read and fully understand *Kids Can Do, Inc.*'s Notice of Policies and Patient Information Practices. I understand that I am responsible for payment of services provided by *Kids Can Do, Inc.* I understand my rights as a patient or guardian of a patient of *Kids Can Do, Inc.* I understand that *Kids Can Do, Inc.* may use or disclose my/this patient's personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my/this patient's personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that *Kids Can Do, Inc.* will consider for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby agree that I am financially responsible for payment of the services rendered by *Kids Can Do, Inc.* and consent to the use and disclosure of this patient's personal health information for purposes as noted in *Kids Can Do, Inc.* Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

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Patient Name

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Patient/Parent/Guardian Signature

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Date

I also authorize *Kids Can Do, Inc.* to use this patient's protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use this patient's protected health information for treatment, billing, or operations related to treatment and billing.

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Patient Name

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Patient/Parent/Guardian Signature

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Date

*Ref: P/P 1-03*