kids can do inc
CHILDREN'S THERAPY CENTER
Speech Therapy • Occupational Therapy • Physical Therapy

Dear Families,

Thank you for choosing KIDS CAN DO to provide therapy services for your child. We are committed to seeing that your child receives the highest quality care in a family friendly environment.

Please take a moment to review and complete the following forms. The **case history form** will give us some basic information about your child. Any additional information you feel will be useful for therapeutic programming is always welcome.

We also require that each family complete an **insurance information form,** and review our **financial policy**. A signed copy of our financial policy is required to ensure that families understand their financial responsibilities regarding payment for services. A representative of our billing department will contact you to review the benefit information quoted *to our office* by your insurance carrier. However, we do highly recommend you call your insurance for this information as well.

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

KIDS CAN DO, INC. FINANCIAL POLICY

updated May 2017

Please review the following Financial Policy, which we require you to read and sign prior to services being rendered.

CANCELLED AND MISSED APPOINTMENTS

A maximum of three cancellations per each scheduled weekly session are allowed per quarter at no charge. Additional cancelled sessions will be billed directly to the client at $25 per scheduled session. ALL NO-SHOW (missed appointments without notice) will immediately be billed to the family at a $50 charge. This fee must be paid prior to the next scheduled treatment session. Lack of payment for a missed appointment may result in the loss of your scheduled therapy time. When cancellations are excessive for two quarters in a row, your child may lose his/her scheduled therapy time. A complete description of our cancellation policy is posted in our waiting room, and is available upon request.

INSURANCE

Kids Can Do, Inc. is a preferred provider for Blue Cross Blue Shield PPO. We are considered a non-preferred, or out-of-network, provider for all other insurance carriers. **We do not accept state-funded insurance policies.**

If you choose to utilize your insurance, we will submit claims directly to your insurance company as a courtesy. All CO-PAYMENTS must be paid at the time that therapy is provided. Office personnel will be expecting payment and can issue a receipt upon request. If a claim has not been paid by your insurance within 45 days, you will be responsible for the balance, regardless of pending expected reimbursement. For patients with UNITED HEALTHCARE, 50% payment is due at the time of service due to their processing and reimbursement history. There will be a $35 service charge for NSF checks presented for payment of services.

If your insurance policy is out-of-network with Kids Can Do, please be aware that coverage and limitations on therapy services are determined by your plan administrator or your insurance company, not by this office. Our usual, customary, and reasonable fees do not necessarily correspond to your insurance company's fee schedule. It is your responsibility to review your insurance policy and to understand your specific therapy benefits. This includes being aware of whether or not authorizations or referrals are required for payment of services. In some cases, obtaining authorizations or referrals will be the **responsibility of the insured**. **Parents assume financial responsibility for any treatment sessions their child attends that are not covered by a current authorization, referral, or physician's prescription.**

If there is a change to your insurance coverage, we ask that you notify Kids Can Do as soon as possible. Any denials or unpaid balances resulting from a termination or change in coverage will be the responsibility of the policy holder.

A 20% discount is available for patients that do not utilize their insurance and choose to pay out of pocket at the time of service. If payment is not received at the time of service, the full therapy charge will be billed directly to the family.

OUTSTANDING BALANCES

Please be aware that balances carried over 60 days will be charged a finance fee of 1.5% (18% annual rate). If no payment is received within 120 days, your account will be subject to further collection activity.

DIVORCE DECREES

Kids Can Do is **NOT** party to your divorce decree. Financial responsibility for minors rests with the **accompanying** adult.

Please contact us with any questions or concerns, and keep a copy of this agreement for your own records.

I have read, understand, and agree to this Kids Can Do Financial and Appointment Policy.

X_____ _____

Signature of Responsible Party Date

INSURANCE INFORMATION FORM

EFFECTIVE DATE _____

Primary Policy **Marketplace Plan: Y or N**

Patient Name:
Policy Holder Name:
Policy Holder DOB:
Policy Holder Social Security Number:
Policy Holder Address:
Policy Holder Phone Number:
Insurance Company:
Identification#
Group#

Secondary Policy **Marketplace Plan: Y or N**

Patient Name:
Policy Holder Name:
Policy Holder DOB:
Policy Holder Social Security Number:
Policy Holder Address:
Policy Holder Phone Number:
Insurance Company:
Identification#
Group#

Kids Can Do has been informed by BCBSIL that they will be informing their members that services received and deemed to be "medically unnecessary" and/or "medically unproven" by the ***insurance carrier's utilization management process****, will* ***not*** *be the responsibility of the member. Kids Can Do is requiring the following disclosure to be signed in order for treatment to begin.*

Annual Medical necessity disclosure/authorization

Required before treatment is initiated

At Kids Can Do, Inc., it is our policy to treat children **only** when services are authorized or prescribed by a physician or other qualified healthcare professional.

At times, however, a therapy plan or procedure may not qualify as being "medically necessary" and/or "medically proven" under the terms, restrictions, guidelines or conditions used by your insurance company and/or insurance plan.

Kids Can Do shares with you the information that we receive from your insurance company in our initial verification of benefits process; however, they always state that "a quote of benefits is not a guarantee of payment".

By signing below, you indicate that you are aware that specific treatments and/or procedures provided at Kids Can Do may be deemed ***medically unnecessary or medically unproven*** by your insurance company. Additionally, you are agreeing that you will be financially responsible to pay for all services listed below, regardless of your insurance company's determination. Additionally, you are agreeing that you will be financially responsible to pay for all services that are provided with a physician's order, regardless of your insurance company's determination.

_____

Patient Name

_____ _____

Responsible party Date

PATIENT INFORMATION CONSENT FORM

(HIPAA)

REQUIRED CONSENT:

I have read and fully understand ***Kids Can Do, Inc.'s*** Notice of Policies and Patient Information Practices I understand my rights as a parent or guardian of a patient of ***Kids Can Do, Inc.*** I understand that ***Kids Can Do, Inc.*** may use or disclose my child'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 ask that Kids Can Do restrict how my child'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 disclosurer of my child's personal health information for purposes as noted in ***Kids Can Do, Inc.*** Notice of Policies and Patient Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____ _____

Patient/Parent/Guardian Signature Date

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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: grandparent, babysitter/caregiver, school therapist, neurologist, psychologist, teacher, etc.)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____ _____
Patient/Parent/Guardian Signature Date

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DRESSING POLICY

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 initial 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: _____

_____

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PHOTOGRAPHY AND VIDEO CONSENT

Child's Name: _____Birth Date: _____

Parent/Guardian Name: _____
Please initial items for which you wish to consent.

_____ 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 or treatment areas. 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, social media, marketing purposes, and/or on the Kids Can Do, Inc. website (www.kidscando.org).

_____ _____
Parent/Guardian Signature Date

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CASE HISTORY FORM

Date completed: _____

Child's Name: _____Child's Date of Birth: _____ Male ( ) Female ( )

Street Address: _____City: _____ State:_____ Zip: _____

Mother's Name: _____ Father's Name: _____

Child's Siblings (and Ages):_____

Home phone: (____) _____ Preferred Contact Method: _____

Cell Phone (M): (____)_____ Cell Phone (F): (____)_____

Work Phone (M): (____)_____ Work Phone (F):(_____)_____

E-mail & Holder's Name: _____

Emergency Contact (other than parents): Name/Relationship: _____

Phone: (_____) _____

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

1. _____ 2. _____

Address: _____ Address: _____

_____ _____

Phone: (_____)_____ Phone: (_____)_____

Fax: (_____)_____ Fax: (_____)_____

Please list any precautions, concerns, and procedures we should be aware of relating to your child's medical status (including seizures, allergies and reactions, or sensitivities, etc.):

_____

_____

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 post-delivery:

_____

_____

Please describe any problems your child may have experienced 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 diagnoses or medical conditions:

Diagnosis/Date Determined

_____

_____

_____

Please list any medications your child currently takes:

Medication	Reason	Dosage and Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were your child's developmental milestones on target? _____ If no, please explain: _____

_____

_____

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 or Deficit Found (list) _____

Does your child have a history of ear infections? _____ If yes,how many? _____

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 or Deficit Found (list) _____

SCHOOL

Please give the name and address of the school that your child currently attends (if applicable):

Name: _____

Address: _____

_____

Phone: (_____)_____

Does your child receive therapeutic intervention through his/her school program? _____

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

Service	Name of Provider:
_____	_____
_____	_____
_____	_____
_____	_____

PARENT/CAREGIVER CONCERNS AND GOALS

Please state your chief concern leading to therapeutic assessment from Kids Can Do, Inc.:

_____

_____

_____

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

1. _____

2. _____

3. _____

_____ _____

Parent / Guardian Signature Date

Additional comments:

NOTICE OF POLICIES AND PATIENT INFORMATION PRACTICES

(HIPAA)

THIS NOTICE DESCRIBES OUR INFORMED CONSENT 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. ATTACHED FORM MUST BE SIGNED AND RETURNED BEFORE SERVICES ARE INITIATED.

Informed Consent Statement

As a parent 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 child's specific diagnosis, insurance carrier, location, 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 and personal needs. I accept that 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 plan will be fully explained to me as well as the pertinence of this treatment to the specific need(s) of my child.

I additionally understand that my questioning of any of my child's treatment while he/she is 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 or full cooperation with my child's 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 child's 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 child's personal health information primarily for treatment, including consultation with other health care providers regarding 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 child's 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 child's 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 child's personal health information. If you provide us with a written authorization to release your child's 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 Policies and Patient Information Practices will be posted in the waiting room and will be available at your request on your next visit. You may also request an updated copy of our Notice of Policies and Patient Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your child's personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your child's records. You also have the right to request a list of instances where we have disclosed your child's 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 child's 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 child's personal health information, please contact our privacy officer 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:

Kids Can Do, Inc..

HIPAA PRIVACY OFFICER

19100 S. Crescent Drive, Suite 101

Mokena, IL 60448

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