New Beginning Pediatric Rehab

~ Maryland's Trusted Rehabilitation Practice ~
(410)796-8499 Office • (877)384-9028 Fax
www.newbeginningpediatric.com

PATIENT/PARENT INFORMATION

Patient Full Name: _____ Patient's Date of Birth: _____

Parent(s) Name: _____ Cell Number: _____

Address: _____ Home Number: _____

_____ Email: _____

How did you hear of us? _____
(Physician,Google,Friend,Facebook,Other)

Authorized method of communication with you relative to appointments, plan of care, & financial matters (check all that apply)*:

Email ☐Yes ☐No **Text** ☐Yes ☐No **Phone** ☐Yes ☐No **Mail** ☐Yes ☐No

Referring Physician: _____ Pediatrician: _____

Address: _____ Pediatrician Phone: _____

_____

Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone number: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Number: _____ Policy Holder's DOB: _____

Group Number: _____

Employer Name: _____ Employer Address _____

** Note: Not all texting and email systems are 100% secure.*

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FINANCIAL, CANCELLATION, & INSURANCE CHANGE POLICIES

BILLING SERVICE: As a courtesy to patients, claims will be submitted to your insurance carrier by NBPR on your behalf. It is your responsibility to understand your benefits and your expected financial responsibility relating to your contract with your insurance company.

ASSIGNMENT OF BENEFITS: I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to NBPR for services provided to me.

FINANCIAL RESPONSIBILITY: I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). I am also responsible for co-payments, co-insurance, &/or deductibles required by my insurance plan and will make payment to NBPR upon receipt of invoice. Such charges will reflect on the member's Explanation of Benefits (EOB) form provided by their carrier to the member and NBPR. Non-covered services also may include those services my therapist determines to be medically necessary, but are later determined unnecessary by the payer. We encourage patients to make payment via Visa/MasterCard through our automatic payment system.

LATE FEE/FINANCE CHARGE: NBPR will charge a $25.00 late fee for any unpaid invoice(s) that is more than 30 days old. NBPR will also charge a recurring monthly 1% finance charge for unpaid invoices.

CANCELLATION POLICY: Unlike many medical practices, appointments with NBPR are longer in duration and require consistency for progress to occur. Your therapist will reserve a dedicated block of time in their schedule for your child's care. Missed appointments cannot be filled by another patient within a short window of time and cannot be billed to your insurance carrier. Repeated cancellations will result in discharge from care due to the negative impact they cause relative to your child's progress & practice scheduling efforts for those children on our wait list for treatment. For weekly appointments, a maximum of 3 cancellations will result in automatic discharge from care since it is a violation of the treatment plan recommended by the therapist and physician.

A courtesy **48 hour notice** is requested for any cancelled appointment while a **24 hour notice is the minimum notification required**. Failure to contact your therapist within 24 hours will result in an **$85 cancellation charge.** Please keep your child's therapist's cell phone number handy.

CHANGES TO INSURANCE POLICY: It is the responsibility of the policy holder to notify NBPR of any insurance policy changes. Many therapy visits need pre-authorization right away, so it is imperative that we have current insurance information on file at all times. Failure to notify the billing office will result in denials and the policy holder will be invoiced for any denied visits.

I have read and understand the above items.

Patient Name _____

Signature of
Patient's Guarantor _____Date_____

Printed name of
Patient's Guarantor _____

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CONSENT FOR MEDICAL CARE & TREATMENT

PATIENT NAME: _____

My child is being treated at New Beginning Pediatric Rehab ("NBPR") for a condition requiring treatment. I consent to all medical care and tests determined by my therapist that are necessary for my child. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of care. I also understand that if I do not follow my therapist's recommendations as they may relate to my child's health that the therapist and this Office will not be responsible for any injuries or damages that are the result of my non-compliance.

A. Such treatment encompassing procedures and medical treatments as ordered by _____ who is my child's ordering physician. I authorize NBPR and their designated representatives permission to communicate & coordinate my child's care with the following:

Pediatrician: Name_____ Phone:_____ Specialty_____

Other Physician: Name_____ Phone:_____ Specialty_____

School System Therapist(s): Name_____ Phone:_____ Specialty_____

Name_____ Phone:_____ Specialty_____

School System Employee(s) Name_____ Phone:_____ Specialty_____

Relative: Name_____ Phone:_____ Relation _____

B. I authorize NBPR and their designated representative(s) to communicate with those mentioned above as it relates to my child's care: (check all that apply)*:

Email ☐Yes ☐No **Text** ☐Yes ☐No **Phone** ☐Yes ☐No **Mail** ☐Yes ☐No

Note: not all texting & email systems are 100% secure

C. I authorize and request my child's ordering physician and New Beginning Pediatric Rehab, Inc. to release all information concerning my child's case history, care and treatment while being cared for by New Beginning Pediatric Rehab, Inc. These records, or review of same can be released to representatives of my insurance company or any other third party source of payment responsible for my bill

D. I understand that NBPR does NOT provide emergency medical care and will call 911 in an emergency situation.

Signature of Patient's Legal Representative_____ Date_____

Printed name of Patient's Legal Representative _____

Relationship of Legal Representative to Patient _____
(e.g., parent, guardian, other, ...)

E. Emergency Contact:_____ Relationship:_____ Phone: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.

1. Uses and Disclosures. We will use your protected health information **(PHI)** for the purposes of treatment, payment and health care operations.

Coordination of Care: PHI will be shared with other health care professionals in order to effectively manage care of the patient. This may include doctors, nurses, technicians and other health care providers.

Payment: Insurance companies require PHI in order to process payments on your behalf for services rendered. Your insurance company may request a review of your medical record to determine medical necessity.

Uses and Disclosures Required by Law: The federal health information privacy regulations either permit or require us to use or disclose the patient's PHI in the following ways: we may share some of the patient's PHI with a family member or friend involved in the care if you do not object. We may use your PHI in an emergency situation when the patient may not be able to express themselves. We may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

Authorization by the patient or legal guardian is required before your PHI may be used or disclosed by us for other purposes.

2. Your Privacy Rights

Restrictions : You have the right to request restrictions on how the patient's PHI is used, however we are not required to agree with the request. If we do agree, we must abide by the request.

Confidential Communications: The patient and/or legal guardian have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI: The patient and/or legal guardian have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments: You have the right to request an amendment be made to your PHI, if you disagree with what it says. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Complaints: If you feel that your privacy rights have been violated, the patient and/or guardian has the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy: We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Our Notice of Privacy Practices is posted on our website at www.newbeginningpediatric.com.

Privacy Contact: If you would like more information about our privacy practices you may contact:

Shari Marchese-Kennedy, MPT
Privacy Office
President

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CREDIT CARD AUTHORIZATION

Name on Card: _____

Card Type: VISA M/C
(circle one)

Account Number: _____ Expiration (Mo/Year): _____

CVV 3 or 4 digit: _____

E-mail address: _____

Patient Name: _____

I agree and authorize New Beginning Pediatric Rehab Inc. to charge the above account for all co-payment, deductible, & co-insurance as dictated by your insurance provider including non-covered services & private/non-insurance related services.

Authorized Signer: _____ Date: _____

Single Family Household (please circle one): YES NO If NO what is custody arrangement: _____

Living Situation: _____

Siblings: _____ Age: _____

_____ Age: _____

_____ Age: _____

Current or ongoing concerns/reason for referral:

MEDICAL INFORMATION:
Diagnoses (list all current & date of diagnosis) :

CURRENT CONDITION:
Please circle all that apply and/or fill in the blanks.

Date of last physical exam: _____ Current weight: _____ Current height:_____

Current Medications/Dosage/Frequency: _____

My child currently sleeps/naps: inconsistently well restless other

My child currently eats/drinks: at regular/irregular intervals consistent/inconsistent amounts

Known Allergies/Diet Restrictions: _____

Are immunizations up to date? Yes No _____

History of major illnesses/hospitalizations: _____

Does your child have a feeding tube or require a ventilator to breathe? _____

History of ear infections? Yes No If yes, how many:_____

Date of most recent hearing test: _____ Results: _____

Where was the test conducted? ___School ___Doctor ___Audiologist

Does your child wear hearing aids? Yes No Describe hearing loss:_____

Date of most recent vision screening: _____ Results:_____

Please describe any vision impairment: _____

How does your child currently move in his/her environment? _____

Any diagnosed mental, emotional, or learning disabilities? _____

Any concerns about physical, sexual, mental, or emotional abuse? _____

Describe your child's current demeanor: (Are they generally happy? Tend to be active? Easily frustrated or have trouble with changes in routine? Do they make friends easily? What are their favorite or most challenging activities?)
_____

_____

_____

Does your child receive behavior therapy or have they received behavior therapy in the past? If yes, please elaborate.
_____

_____

PREVIOUS & CURRENT THERAPIES AND/OR SPECIALISTS: please list names, types and dates seen. If applicable, please provide copies of relevant evaluations and reports (occupational therapy, speech-language therapy, psychoeducational, neurological, IEPs, etc.)

_____

_____

_____

_____

_____

_____

_____

DEVELOPMENTAL INFORMATION
MOTHER'S HEALTH DURING PREGNANCY: *Please circle Yes or No to the following questions and remark in the space provided.*

1. Were any drugs or medications taken during pregnancy? Yes No _____
2. Was the pregnancy full-term? Yes No _____
3. Was the delivery normal? Yes No If no, please specify (cesarean section, breech, cord around neck, forceps used):

   _____

CHILDS BIRTH: *Please circle all that apply and/or fill in the blanks.*

1. Child's weight at birth: _____ Length of infant's hospital stay: _____
2. Was your infant admitted to the NICU? Yes No If yes, length of stay? _____
3. Were there any complications? Seizures jaundice congenital defects other: _____
4. Was there a need for: oxygen transfusions tube feedings other:_____
5. Was the child breast fed or bottle fed? _____ When weaned? _____
6. Did the infant have any feeding problems? _____
7. Describe your child's demeanor and behavior as an infant: _____
8. Has your child had a tongue tie correction surgery? Yes No If yes, at what age? _____

DEVELOPMENTAL MILESTONES:
Please list the age (in months) at which your child did the following and answer the questions that follow.

Roll _____ Sit _____ Belly crawl _____ Crawl on hands/knees _____ Walk _____ Stand _____

Run _____ Skip _____ Say first word _____ Finger feed _____ Use spoon/fork _____

Sleep through night _____ Drink from cup _____ Dress independently _____

1. Any concerns or questions about your child's development?_____

_____

2. When did your child gain bladder control? _____ Bowel control? _____

SOCIAL/EDUCATIONAL HISTORY:

School/Day Care: _____ Grade: _____

Teacher's Name: _____ Phone: _____

Activities your child enjoys at home or school :

_____

_____

_____

Does your child prefer to do these activities alone or with other children/siblings? _____

Are you confident your child's current school is meeting your child's needs? _____ YES _____ NO (*please elaborate)*

_____

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WHAT ARE THE THREE OR FOUR MOST IMPORTANT GOALS YOU WISH TO HAVE ADDRESSED DURING YOUR CHILD'S THERAPY PROGRAM?

_____

_____

_____

_____

_____

PLEASE USE SPACE BELOW FOR FURTHER COMMENTS OR SHARING ANYTHING YOU THINK WE SHOULD KNOW ABOUT YOUR CHILD:

_____

_____

_____

_____

_____

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POLICIES FOR SIGNATURE

*In cases of separation and/or joint custody, legal documentation of custody arrangements must be provided prior to services and both parents/guardians must sign signature forms.

Client Name: _____ **DOB:** _____

Please review and sign the following:

Acknowledgement of Notice of Privacy Practices
I acknowledge the NBPR will use and disclose my child's personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I further acknowledge that NBPR Notice of Privacy Practices, which is available at the initial appointment and/or upon request, provides further detailed information about how NBPR may use/and or disclose protected medical information about my child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Client/Parent or Guardian Signature Date

Photograph and Video Release Form
NBPR is a private practice, focusing on interventions with people of all ages, but most of children. Additionally, this practice is involved in the education of future therapists. As such, we may take photographs or videos of children or family members participating in services. The photographs and videos may include interviews, assessments, interventions, and/or other clinical activities. The rights, titles, and interest of these materials belong to NBPR, which reserves the right to edit the material.

I _____ (please print name) voluntarily consent to the taking of videos or photographs of myself or my child _____ (print child's name)
I understand that these photographs or videos may be used for educational purposes, intervention purposes, and/or media purposes in education training programs or media publications. I understand that the photographs or videos may be used to create education training videos and may be used by NBPR for seminars, staff/student training, workshops or on the NBPR website or social media page(s). Some video or photographic material may be included in future training videos.. Specific names of children and other family members will not be used in photographs or videos without separate consent.

I give permission for the use of photographs or videos for educational purposes, for news or other media, for NBPR website & social media and for training videos.

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Client/Parent or Guardian Signature Date

Frequently Asked Questions - Treatment Area Policies

WE LOVE ALL OUR PATIENTS AND THEIR FAMILIES!

We appreciate your help as we strive to maintain a therapeutic environment for our patients.

1. May I drop my child off for therapy, leave, and then pick them up at the end of their session? NO, DROP OFF IS NOT ALLOWED. PARENTS ARE REQUIRED TO REMAIN ON PROPERTY DURING THERAPY SESSIONS.

2. Do I need to stay in the treatment area with my child during their therapy sessions? No, a parent does not need to stay in the treatment area with their child during therapy sessions unless your therapist requests you be present for discussion and instruction. To minimize distractions and maximize therapy sessions we suggest parents stay in the waiting area for patients 18months and older.

NOTE: All treatment plans are individualized so please ask your therapist what arrangement works best for your child. Also please keep in mind circumstances may vary among patients. We appreciate your understanding.

3. How many parents/guardians are allowed in the Therapy Gym at one time? To minimize distractions and maximize therapy sessions we respectfully request only ONE parent per patient in the Therapy Gym or "common" areas at a time. Please provide your therapist notice if more than one parent or family member will be attending therapy so a treatment room can be reserved.

4. Is it ok to bring siblings to therapy sessions? Yes, this is allowed but not encouraged. We recommend other arrangements be made for siblings whenever possible. If a sibling needs to come along we require a parent stay in the waiting area to supervise any sibling 12 and under. If a sibling must be present in the treatment area during a therapy session please notify your therapist prior to your visit to allow the therapist time to reserve a treatment room.

5. My son has therapy today however his sister is home from school due to illness. Can I still bring my son to therapy and wait in the waiting room with my daughter? Please keep sick children at home. For the health and safety of our patients and staff the illness policy applies to ALL children, including siblings. NBPR Illness Policy - Please contact your therapist and cancel if your child is suffering from any of the following: Uncontrollable symptoms of coughing, sneezing and runny nose; fever of 100 degrees; bad cold with thick green discharge; vomiting or diarrhea; strep throat that has not been treated at least 48 hours; pinkeye, lice, chickenpox, or anything else very contagious. PLEASE REVIEW OUR CANCELLATION POLICY.

6. Do you have a Hand Washing Policy? Yes. We require ALL patients wash their hands before sessions with soap or hand sanitizer. Hand sanitizer is available throughout the clinic and soap is available in the lavatory.

7. What is the NBPR Cell Phone Policy? Cell phone usage should not disturb those around you. The privacy of patients and staff must be respected. No photos or videos.

THANK YOU FOR YOUR COURTESY,

NEW BEGINNING PEDIATRIC REHAB STAFF

NBPR CANCELLATION POLICY

FROM THE NEW PATIENT PAPERWORK PACKET, WHICH WAS SIGNED BY PARENT/GUARDIAN PRIOR TO BEGINNING THERAPY

"A courtesy 48 hour notice is requested for any cancelled appointment while a 24 hour notice is the minimum notification required. Failure to contact your therapist within 24 hours will result in an $85 cancellation charge. Please keep your child's therapist's cell phone number handy."

Exception #1…Illness:
(2 hour notice, or the $85 fee will be charged. Please strive for 24 hr notice)

Any contagious condition must be CLEAR for 24 hours before your child, any siblings, or YOU come to NBPR. This includes:

- Fever higher than 100 degrees
- Vomiting or diarrhea
- Bad cold with thick green nasal discharge
- Pinkeye, lice, impetigo, strep throat, flu, or anything else that is easily spread between people

Exception #2…Inclement Weather:
(2 hour notice, or the $85 fee will be charged. Please strive for 24 hr notice)

NBPR does not follow Howard County Public School delays or closures. Even when schools are closed, we do our best to provide therapy as usual. But… safety first! If driving conditions are unsafe in your neighborhood, please give at least one hour notice.

Please give as much possible notice of your cancellation, so we can offer that time for make-up sessions, co- treatments, or for patients on the wait list. We too, will give you as much notice as possible for any absences of our own. Thank you for understanding!

REPEAT CANCELLATION POLICY

Your therapist reserves a dedicated block of time in their schedule for your child's care. A maximum of 3 cancellations will result in removal from the reserved treatment schedule.