seaShore
PEDIATRIC THERAPY CENTER

230 Division Street
Manahawkin, NJ 08050
609-607-7400

Child's Name: _____

Date of Birth: _____

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____

Mother or Legal Guardian: _____ **Father or Legal Guardian**: _____

DOB: _____ DOB: _____

Please check if it is ok to leave a message	Yes	No		Yes	No
Home Ph.: _____	☐	☐	Home Ph.: _____	☐	☐
Cell Ph.: _____	☐	☐	Cell Ph.: _____	☐	☐
Work Ph.: _____	☐	☐	Work Ph.: _____	☐	☐

Best number to reach you at: _____

Physical Address: _____ Physical Address: _____

_____ _____

Mailing Address: _____ Mailing Address: _____

_____ _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Who referred you to our office? _____

Child resides with? _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ **PHONE:** _____

INSURANCE INFORMATION (please fill out ALL areas)

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Claims Address: _____ Claims Address: _____

_____ _____

Phone Number: _____ Phone Number: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

I DO NOT YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. Initial _____

Emergency Medical Release

In the event medical attention is required for your child while the premises of SPTC, PC, we need your authorization to implement treatment. Please read and sign statement below.

As legal guardian of _____, I give my permission for SPTC, PC to contact emergency personnel in the event of a medical emergency.

Parent/Legal Guardian Signature _____ **Date**_____

seashore
PEDIATRIC THERAPY CENTER

230 Division Street
Manahawkin, NJ 08050
609-607-7400

Child's Name: _____

Date of Birth: _____

PATIENT AGREEMENT

Seashore Pediatric Therapy Center, PC offers Physical Therapy, Occupational Therapy, and Speech-Language Pathology 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 Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology 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 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.

seashore
PEDIATRIC THERAPY CENTER

230 Division Street
Manahawkin, NJ 08050
609-607-7400

Child's Name: _____

Date of Birth: _____

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 (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 Seashore Pediatric Therapy Center, PC 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, personal checks, and credit cards (VISA, MasterCard, and Discover Card); 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.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your child's caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone at (609) 607-7400. A member of our management team will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Seashore Pediatric Therapy Center, PC 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**

_____

Relationship to Patient

seashore
PEDIATRIC THERAPY CENTER

230 Division Street
Manahawkin, NJ 08050
609-607-7400

Child's Name: _____

Date of Birth: _____

FINANCIAL POLICY

Welcome to our office! We are committed to providing you with the best possible care. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, MasterCard, and Discover Card. **Please understand that you are financially responsible for all charges, whether or not they are paid by insurance.**

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.

2. Should your insurance coverage change, our office should be notified within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account and all future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.

3. Our fees are generally considered to fall within the acceptable range by most insurance carriers and therefore are covered up to the maximum allowance determined by each carrier. This applies to the companies who pay a percentage (such as 50% or 80%) of the usual, customary, and reasonable rate (UCR). This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. **Please note insurance companies may indicate the services were not medically necessary and claim that, because Seashore Pediatric Therapy Center, PC is a preferred provider, you do not have to pay the balance. This is NOT the case and you will be billed for the services.** This office cannot accept responsibility for negotiating settlements on disputed claims.

5. Any returned checks will be subject to a NSF fee of $25.00 which will be due at the next visit.

6. Accounts that are past due will incur a finance charge at the rate of 10.5% annually.

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I hereby understand the above financial policy and agree to abide by it.

_____ _____

Parent or Guardian Signature **Date**

seaSHore
PEDIATRIC THERAPY CENTER

230 Division Street
Manahawkin, NJ 08050
609-607-7400

Child's Name: _____

Date of Birth: _____

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**

Patient Authorization

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT) (Initial: _____)
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Seashore Pediatric Therapy Center, PC.. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations.

RELEASE INFORMATION AND CONSENT FOR TREATMENT (Initial: _____)
All information provided herein is true and correct.
I am aware of my child's diagnosis and wish him/her to receive treatment at Seashore Pediatric Therapy Center, PC. I permit its employees and all other persons caring for my child to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.
I give permission to Seashore Pediatric Therapy Center, PC to release information, verbal and written contained in my child's medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my child's treatment or payment for services provided.
I understand that Seashore Pediatric Therapy Center, PC also serves as a training and research facility and at times other therapists may be observing, handling, or have access to my child's medical information. I give my permission for Seashore Pediatric Therapy Center, PC to use photographs and video taken of myself or my minor child during therapy sessions for educational, informational and promotional materials.
I authorize Seashore Pediatric Therapy Center, PC to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment.
I understand that I may revoke this authorization in writing at any time by sending a signed and dated written statement to Seashore Pediatric Therapy Center, PC that I am revoking my authorization to disclose health records.

AUTHORIZATION TO PICK-UP AND SESSION DISCLOSURE (Initial: _____)
I do hereby authorize Seashore Pediatric Therapy Center, PC to release my child to the above listed people in the event I am unable to pick him/her up myself. I release Seashore Pediatric Therapy Center, PC from any and all responsibility for problems that may develop when such persons take my child from the premises.

ASSIGNMENT OF BENEFITS (Initial: _____)
I authorize payment directly to Seashore Pediatric Therapy Center, PC for services and to bill and release payment directly to Seashore Pediatric Therapy Center, PC for any orthotic or prosthetic services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original

OUTPATIENT CANCELLATION POLICY
Please make all efforts to arrive for your child's Physical, Speech/language or Occupational therapy appointment on time. Your therapist has many people to see and makes every attempt to keep you on schedule. If you are unable to keep your appointment, please call and cancel so that we may adjust the therapist's schedule. We ask for at least a 24-hour notice for cancellations. We are aware that emergencies occur, but would prefer a cancelled visit to a "no show."
Should you miss an appointment with less than 24-hour notice or not show up for a scheduled appointment with no attempt to contact us, you will be charged and further sessions will be suspended until we hear from you. If the therapist is unable to keep his/her appointment, you will be notified as soon as the therapist is aware and an alternate appointment will be made. Thank you in advance for your cooperation in this matter. Our mutual goal of providing quality therapy for your child can best be served if we all communicate changes in our schedules. **Please sign below to indicate awareness of this policy.**

Signature: _____ **Date:** _____

WAIVER
I, _____ the parent or guardian of _____ (thereafter referred to as "my child") give permission for my child to participate in Seashore Pediatric Therapy Center, PC programs and services. I hereby release Seashore Pediatric Therapy Center, PC principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Seashore Pediatric Therapy Center, PC program, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in Seashore Pediatric Therapy Center, PC programs. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/ therapy equipment during the program at the Seashore Pediatric Therapy Center, PC center or at clients homes. I understand that I should be present at all times during delivery of service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Seashore Pediatric Therapy Center, PC in connection with their programs from all liability as herein described.

Guardian Name: _____ **Guardian Signature:** _____ **Date:** _____ **Acknowledged By:** _____

PAYMENT GUARANTEE
I agree to pay Seashore Pediatric Therapy Center, PC for the services provided to my child or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.
I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my child's treatments unless agreed to in writing by myself and a representative of Seashore Pediatric Therapy Center, PC.

Parent/Guardian signature_____**Date:**_____ **Social Security #** _____-_____-_____

FINANCIAL POLICY
Our staff verifies your insurance benefits prior to the onset of services as a courtesy to you. Although we strive to obtain the most accurate information possible, the quoted benefits from your insurance company are not a guarantee of payment. Should you need the detailed information about your coverage, please contact your insurance company directly. You are responsible for you insurance deductibles, co-payments and supplies at the time of service. In the event we receive a denial from your insurance company, and you choose to continue with therapy, payment is due at the time services are provided. If payment is not received from your insurance company within 60 days from the date of filing, you will be responsible for payment in full. We will supply any documentation requested by you insurance company to expedite payment. We accept cash, checks, Visa, and MasterCard. There is a $25 service charge for all checks returned. No shows will result in a service fee, which will be due and payable on your next visit. If you request your therapy charges to be billed to party other than your insurance company, please provide the necessary billing information to our office. All billing directed to attorneys will have a lien placed on the account. You are financially responsible for payment of services rendered. In the event the account becomes delinquent, and is therefore in default of payment, a collection fee will be added to the unpaid balance for the recovery of this debt. If you have any questions or concerns regarding the financial policy, please speak to the Clinic Director or Patient Service Manager. I understand that I am financially responsible to Seashore Pediatric Therapy Center, PC for any changes incurred during the course of treatment and verification of benefits does not guarantee payment by the insurance company. I hereby authorize payment be made directly to Seashore Pediatric Therapy Center, PC.

_____ _____
Signature of Responsible Party **Today's date**