the pediatricplace
physical therapy • occupational therapy • speech therapy

210 S. 2nd Street, Suite A
Clinton, MO 64735

(P) 660-885-2394
(F) 660-383-1650

1800 W. Irish Lane
Knob Noster, MO 65336

(P) 660-687-0187
(F) 660-687-0221

PATIENT REGISTRATION FORM

Patient Information:

Patient Name:_____Sex_____DOB:_____
Last First MI MM/DD/YYYY

Address:_____
Street City State Zip

Email Address: _____

(Your email address will be subscribed to our website in order for you to receive important announcements and information)

Primary Care Physician:_____Phone_____

Primary Dentist: _____Phone_____

Is the patient covered by MO Medicaid: YES _____ NO_____ If yes, Medicaid ID Number _____

Where does the child attend School:_____Grade:_____

Food Allergies:_____Latex Allergy?_____

Any other allergies or drug allergies:_____

Adverse reactions:_____

Has your child been hospitalized in the past 12 months? YES_____ NO_____ If YES, please explain _____

_____

_____

Does your child have any of the following medical conditions (select all that apply)?

☐ Asthma ☐ Failure to Thrive ☐ Neurological Condition ☐ Autism ☐ Head Injury

☐ Respiratory Issues ☐ Constipation/GI Issue ☐ Hearing Loss ☐Seizure Disorder

☐ Ear Infections ☐ Heart Issues ☐ Sleep Apnea/Snoring

Other:_____

Does your child have any of the following Mental Health conditions (select all that apply)?

(Please provide your Mental Health provider, any or all medical confirmation of diagnosis listed below from your Primary Care Physician)

Mental Health Concerns:

☐ Post Traumatic Stress Disorder ☐ Oppositional Defiant Disorder ☐ Anxiety

☐ Attention Deficit/Hyperactivity Disorder ☐ Depression ☐ Eating Disorders ☐ Sexual Abuse

☐ Suicidal or Suicidal Ideations ☐ Substance Abuse ☐ Behavior Issues

Other:_____

Applied Behavior Analysis:
(Please provide information if your child is going to attend ABA Therapy with The Pediatric Place)

Were there any Prenatal/Perinatal events? (physical, psychological, social, intellectual or academic) Please list them here: _____

_____

_____

_____

Has your child had any Medical or Behavioral Health or other intensive autism related services? Please provide known medical conditions, dates of previous treatment, current treating clinicians and current therapeutic interventions and responses: _____

_____

_____

Are there any community resources (support groups, social services, school based services, other social supports) that you are currently utilizing? _____

_____

_____

_____

Would you like The Pediatric Place to provide your child's primary care physician with a copy of the ABA assessment and evaluation, if your primary care physician is not the provider that referred your child to our offices? Yes _____ No _____

Responsible Party (Parent/LegalGuardian)

Parent 1: _____DOB:_____
Last First MI MM/DD/YYYY

Relationship to Patient:_____

Address, if different from patient: _____
Street City State Zip

Primary phone:_____ Work phone:_____

May we contact you at work? YES _____ NO_____ Are we billing insurance? YES _____ NO_____

Insurance Company: _____ Group/PolicyNumber:_____

Member ID Number: _____
MM/DD/YYYY

Parent 2: _____DOB:_____
Last First MI MM/DD/YYYY

Relationship to Patient:_____

Address, if different from patient: _____
Street City State Zip

Primary phone:_____ Work phone:_____

May we contact you at work? YES _____ NO_____ Are we billing insurance? YES _____ NO_____

Insurance Company: _____ Group/PolicyNumber:_____

Member ID Number: _____
MM/DD/YYYY

Assignment of Benefits

I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to The Pediatric Place, LLC for their services.

I authorize The Pediatric Place, LLC to release to all insurance companies and/or compensation carriers only such diagnostic, therapeutic, and financial information as may be necessary to determine benefits entitled and to process payment claims for health services that were provided.

The insurance information collected is an attempt to collect debt. Any information obtained will be used for that purpose.

I understand and agree that I am financially responsible for any and all charges not covered by assignment.

_____ _____

Signature of responsible Party or Parent Date

Notice of Privacy Practices

This notice describes how health information about your child may be used and disclosed and how you can get access to this information. The federal government has legislated the Health Information Portability and Privacy Act (HIPAA). The rules regulate the privacy and accessibility of health information regarding your child's care at The Pediatric Place, LLC. We must follow these privacy practices that are described in this notice until they are changed. You may request a copy of this notice at any time, as applicable by law. Any changes will be added to this form and made available to you.

Use and Disclosure Information

Treatment - We may use or disclose your child's health information to plan a course of treatment that includes evaluation goals and treatment approach. At times, your child's medical information may be reviewed by a student intern at our facility. In addition, your child's medical records will be provided to your health plan and referring physician. Your child may receive therapy services in the same room as another child. When in the treatment area, your child's goals and data pertinent to your child's treatment may be discussed with other professionals and family members.

Payment - We may use and disclose your child's health information to obtain payment for services we provide. A bill may be sent to you or your health insurance payer. The information on the bill may contain information that identifies your, your spouse or your child. This information may include the child's date of birth, diagnosis and procedures or supplies used.

Appointments - We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text message reminders, postcards or letters).

Check-In - Your child's name may be called. Your child's name may be written on a sign in sheet.

Schools & Agencies - We may provide information requested for IEPs and evaluations with other professionals. We may disclose your child's information to doctors and other health professionals regarding your child's care with us.

Other Permitted Uses and Disclosures

To public health authorities charged with preventing or controlling disease, injury or disability. We will notify appropriate persons if we suspect child abuse or neglect.

We may need to provide medical information regarding your child to legal/judicial/administrative and law enforcement persons. We may need to send your information regarding your child's care or billing issues through the mail. We may also send your information about groups and programs. This information may come in a marked envelope with our address on it. We will not use or disclose your child's health information without your written authorization.

Patient's Rights

- You have the right to view your child's health record and request a copy of it. There may be a copying and postage fee. You may be asked to provide proof of guardianship or parental rights.
- You may request an amendment to your child's record. We are not required to make this change, but it will be noted in the record.
- You may restrict anything in our privacy act by completing a restriction request form. We are not required to honor your request but will make all efforts to accommodate reasonable requests.
- Provide written authorization for uses and disclosures not otherwise permitted by law.

If you believe your privacy rights have been violated, you can file a complaint with our privacy officer or with the Secretary of Health and Human Services.

Secretary-US Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

I have read and understand/agree with The Pediatric Place, LLC's Privacy and Policy Act.

_____ _____

Signature of responsible Party or Parent Date

Office policies, Notices, & Consents

Please Initial each line indicating understanding and consent

_____**1. Payment**: Payment is due at the time of each service unless a payment contract has been established and signed (see patient payment contract). Payments are accepted in cash, check, credit card, and HRA/.HSA cards. Receipts are available upon request.

_____**2. Appointments**: Scheduling your appointments is done in advance and typically carried out several months in advance in the same time slot. This is now your child's reserved time slot; occasional changes can be made as availability allows, but please be mindful of scheduling other activities during this time. Please understand that it is not always possible to move your appointment to schedule around social, extracurricular, or other events. Regular attendance is important both for your child's success and for your claims to be paid. Many insurance companies will deny claims if progress is not being made or attendance is irregular.

_____**3. Vacation and Holidays**: All families and therapists take individual holidays. Please notify the front desk staff or your therapist of vacation plans at least 7 days in advance so schedule changes can be accommodated. Your therapist will communicate holidays and vacation days with you.

Cancellations:

_____ **4. Emergency**: Cancel by 9:00 AM: Emergency cancellations are due to illness of child or other family member or death in the family. Appointments must be canceled before 9:00 AM on the day of the appointment. If you do not plan to send your child to school, please call first thing in the morning to report the illness and cancel therapy for that day. We do have secure voicemail that is checked first thing in the morning so you can also leave us a message before the clinic opens. On occasion, children are sent home during the day from school, or you may have an unexpected event such as a car malfunction. It happens occasionally to all of us. Please call the clinic as soon as possible to schedule your child's make-up session.

_____**5. Non-Emergency**: Minimum 24-hour notice: This includes cancellation for vacations, pre-planned doctors appointments, family events, parties, sports events, babysitting issues, etc. This includes anything not considered an "emergency" (see above). These appointments must be canceled with a minimum 24-hour notice, so your child's time slot can be made available to other families while you are away. If non-emergent cancellations become excessive, your child may lose their "reserved" weekly spot and be put on our flexible schedule or back on our waiting list.

_____**6**. Please **DO NOT** bring your child to the clinic if they have a fever, strep throat, unidentified rash, diarrhea, vomiting, or any highly contagious illness such as pink eye. This applies to all children in your care, even if they are not being seen by a therapist. If they are too sick or would not be permitted to attend school, they should not come to the clinic. Your child must be fever free for 24 hours before returning to in-person therapy. Alternative accommodation for therapy is available with enough notice and if your child feels well enough to participate. If you report to the clinic and your child appears ill, you will be billed the private pay rate for that session and be sent home.

_____**7. Inclement Weather**: Cancel by 9:00 AM: When a storm is expected or traveling on the roads could be dangerous, the clinics usually close. Please call your clinic, check our social media for closure information, or contact your therapist directly if you are unsure of the weather status. We understand that some families live far away or in remote locations, where travel could be more severely impacted by the weather. In situations where you may choose to stay home with your child, please follow the procedure for Emergency Cancellations (see above). Alternative accommodation for therapy is available in most situations. At TPP we are committed to your child receiving their prescribed therapy time each week. When weather conditions are poor and your child is unable to attend their scheduled appointment in person, our therapists are ready to provide therapy via teletherapy. Do not worry if your child is not of the age to sit in front of the screen, we can utilize this session to communicate with you regarding your child's goals, progress, strategies for home programming, etc. Please do not underestimate your child's ability to meet with their therapist over a screen. Our therapists are equipped with treatment strategies specifically for these situations. Regression is not an option during times of inclement weather. If you are not able to attend your scheduled session in person, please call the office and our receptionist will switch the appointment to Teletherapy.

_____**8. Overall Attendance**: Regular attendance during your child's reserved time spot is expected. Progress depends upon consistent attendance. If you are covered by insurance, your policy requires you to have regular attendance in order to show progress or claims and/or prior authorizations for services may be denied. If attendance rates fall below 80% (unless previously arranged with the clinic), your reserved time slot may be forfeited, and therapy will be terminated. If your child has 3 no show/no call incidences at any time, your child will be removed from their regularly scheduled appointment times and placed on a flexible schedule. Front desk staff will communicate with you via email and/or phone call/voice message to discuss the change to flexible scheduling. A flexible schedule means a child does not have a standing, set, weekly appointment, but instead, parent/caregiver must arrange appointments on a weekly basis and is dependent on therapist availability.

_____**9. Lateness**: Therapy appointments run on a schedule, directly on the half hour. When families arrive late, we are not always able to see your child for the full 30 minutes allotted to them, which affects progress and attendance. Additionally, if you need to speak with your child;s therapist for an extended period, please make arrangements to do so during an unoccupied time slot. Your therapist will be happy to help find a good time for this to occur.

_____**10. Waiting Room/Restroom**: The waiting room is a place for families to relax and socialize before, and sometimes after an appointment. Please refrain from eating or drinking in our waiting area, loud/excessive cell phone conversations, or loud play with your children. This can be disruptive to office staff and therapy sessions in progress. The restroom is for all patients and families attending scheduled therapy. Please do not flush sanitary products in the toilet and please dispose of soiled diapers in the covered pail provided. Please supervise young children while they use the restroom facilities and if an accident happens, please notify the front desk staff immediately.

_____**11. Observations and Homework**: A parent or caregiver must be present in the facility while the child is with their therapist unless previously arranged with therapist/office staff. This is not a drop off facility; daily carryover is essential to your child's progress. It is critical that parents/caregivers observe sessions/receive updates from therapists and continue working on goals at home. Activities learned during the child's session should be practiced 3-4 times weekly for 10-15 minutes. Therapists from other facilities who work with your child in other areas are welcome to attend sessions in our clinic by scheduling an appointment to observe. They will be required to sign a "confidentiality disclaimer" at the time of attendance. Last-minute drop-ins cannot be accommodated.

_____**12. Discontinuation of services**: We request that you give us 14 days notice so we may complete any unfinished evaluations and prepare a discharge report for your child. If you happen to be relocating and would like to take copies of your child';s records with you, please let us know when you give the initial notice of discontinuation. Preparing documents can sometimes take a few days and we would like to have them ready for you on your final visit. We are also happy to fax records to future providers with a signed Release of Information including the new provider's name and contact information.

_____**13. Video/Security**: I understand that in person therapy sessions may be recorded via audio/video tape for purposes of evaluating therapist effectiveness and for the safety of the patients and staff. I understand that confidentiality and safety of all recorded sessions will be maintained, and only authorized staff will have access to the recorded sessions. I understand that interns or trainees of The Pediatric Place, LLC may review these sessions for instruction or clinical supervision purposes only that confidentiality disclaimers will have signed prior to any intern/trainee instruction.

_____**14. Photo Release**: I consent and give permission for The Pediatric Place, LLC to use photographs and/or videos of me and/or my child in publications, news releases, social media platforms, and in other communications related to the mission of The Pediatric Place, LLC.

_____**15. Telehealth**: I consent to telehealth (as necessary) for occupational, physical, speech, counseling, dietetics, or applied behavioral analysis therapies

1. **During a telehealth session**:
    a. Details of medical history, examinations, x-rays, and tests may be discussed with other health care professionals using interactive video/audio/telecommunications technology.
    b. A physical examination may take place.
    c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
    d. Video/audio/photo recording may be taken of you during procedure/service.
2. **Medical Information & Records:** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation/therapy. Not all telecommunications are recorded and stored. Dissemination of any patient identifiable images/information from telehealth interactions will not occur without your consent.
3. **Confidentiality**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telehealth consultation/therapy, and all existing confidentiality protections under state and federal law apply to information disclosed during telehealth sessions.

4. **Rights**: You may withhold or withdraw your consent to telehealth consultation/therapy at any time without affecting your right to future care or treatment.
5. **Disputes**: contact The Pediatric Place, 210 S. Second Street, Suite A, Clinton, MO 64735.
6. **Risks, Consequences & Benefits**: You have been advised of all the potential risks, consequences, and benefits of telehealth. Your health care provider has discussed with you the information provided above.

I hereby give The Pediatric Place, LLC permission to evaluate and/or treat my child, and I understand there will be written, oral, and electronic communication between care providers, physicians, insurance companies, and The Pediatric Place, LLC staff.

My/Our signature (s) below indicate (s) understanding of the above and consent to treatment.

_____ _____

Signature of Parent #1, Responsible Party, or Patient Date

_____ _____

Signature of Parent #2, Responsible Party, or Patient Date

Release of information

Patient's Name: _____ DOB: _____
Last First MI MM/DD/YYYY

Parent/Guardian: _____ DOB: _____
Last First MI MM/DD/YYYY

1. I hereby authorize any physician, clinic, hospital, institution, or school to release medical and psychological information regarding me and/or my child _____
Child's Name
to The Pediatric Place, LLC. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize The Pediatric Place, LLC and/or its employees to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

2. I hereby authorize The Pediatric Place, LLC to release therapy reports regarding me and/or my child _____ to my child's physician, clinic,
Child's Name
hospital, institution, school, and/or other: *(Please list anyone who will be bringing your child to therapy other than Parent/Legal Guardian)*: _____

_____

* Unless otherwise indicated, this authorization includes the release of information concerning HIV testing/treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions.

_____ _____
Signature of Parent or Responsible Party Date