NEW PATIENT ORIENTATION/PAYMENT FOR SERVICES RENDERED

Welcome to **Looking Ahead Pediatric Physical Therapy, PLLC**. You have chosen to have your child evaluated and treated for physical therapy for your child's condition. It is important that you understand what to expect from your treatment and what you can do to improve your chances for a successful outcome.

PRIVACY POLICY: I understand I have received and read a copy of **Looking Ahead Pediatric Physical Therapy, PLLC** HIPPA Notice of Privacy Practices. I also understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my health information to another entity (my doctor, insurance company, etc.) and I consent to such disclosure for these permitted uses, including via fax or email.

Is there anyone other than a legal guardian involved in the care of your child or payment related to the care of your child that we can share your health information with? ☐ **YES** ☐ **NO**
If yes, Contact Name/phone#_____

PAYMENT FOR SERVICS RENDERED

FEES/CHARGES: Your visit may include distinct services, which incur separate charges. The total charges of your initial visit may include an evaluation charge, in addition to separate charges that reflect the therapeutic services that are provided (e.g.: exercise instruction, manual therapy, therapeutic activities) as well as any modality services that are provided (e.g.: taping). Subsequent visits will be billed similarly; in that, your bill will reflect charges for the various services that are provided on that visit. If you have any questions or concerns regarding the services that are being planned for a given treatment session, please alert your therapist at the beginning of the appointment so that we can better serve your needs. Additionally, since treatment services may vary over the course of your treatment, the total charges for each session may vary for different dates of service. If you would like a summary of our fee schedule, please ask for a copy at the front desk.
By signing this form, you acknowledge that you have received a GOOD FAITH ESTIMATE prior to your first visit based on the benefits your insurance has provided to us at the time of verification.

I understand that Looking Ahead Pediatric Physical Therapy, PLLC files my claims to my insurance provider as a courtesy but does not accept responsibility for any misinformation Looking Ahead Pediatric Physical Therapy, PLLC received. I am responsible for negotiating the settlement of any disputed claims and for all charges, regardless of anticipated insurance coverage. This has been explained to me and I understand my financial responsibility.

PAYMENTS: Deductible payments, copayments and coinsurance payments are expected on the date of service. Payments can be made with credit cards, HSA cards, debit cards, checks, and cash. A receipt will be generated and sent via email/text per parent preference.

IF YOU ARE UNABLE TO ATTEND ONE OF YOUR CHILD's SCHEDULED APPOINTMENTS, please provide 24 hours notice. It is in your be interest for your child's developmental progress to make up that missed appointment on a different day that week to ensure your child's condition does not regress.

CANCELLATION AND NO SHOW POLICY: It is very important that you keep all scheduled appointments because your child's treatment program is progressive in design. Missed appointments may reduce your child's successful recovery. If you must cancel an appointment please give us at least 24 hours notice**. If you notify us less than 3 hours of your scheduled appointment, you will be charged a $25 office visit cancellation fee. If you fail to call us/no show for your appointment, you will be charged a $50 no show fee. Cancellation/No show fees will not be covered by your insurance.**

IF YOU MISS 3 SCHEDULED APPOINTMENTS, a notice will be sent to your referring physician informing him/her that they treatment plan has not been adhered to and it is at your therapist's discretion to continue treatment or discharge your child. We understand there are many legitimate life events such as illness, family emergencies, hospitalization, and uncontrolled circumstances that occur and we will always take these into consideration.

RUNNING LATE: All of our treatment sessions are scheduled by appointment only. If you are more than 15 minutes late, we may need to alter your treatment program for that visit or reschedule your appointment for another day, at the discretion of your child's therapist.

THERAPY:

- Your child's first visit will consist of an evaluation to enable us to design a treatment program for your child's condition. We will explain what our evaluation findings are and review the recommended treatment program for your child.
- Please try to perform the home exercise program as instructed by your therapist. It is a **very important** part of your child's recovery. Compliance with the home program will significantly improve your child's outcome.
- Always alert your therapist if you have a negative reaction to a treatment session, or if you believe you are doing an exercise at home that is irritating your condition. This feedback is important, since it helps us adjust and individualize your program for better outcomes.

PROGRESS NOTES: Please inform us a few days in advance before you re-visit your physician. We will do our best to email or fax a progress note to your child's doctor before his/her next appointment to their office.

I have read and understand the above information.

Signature:_____ Date:_____

_____ _____

Patient's Printed Name Relationship to patient

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_____

Parent/Legal Guardian Printed Name Relationship to patient