Waypoint pediatric therapies

Navigating a path to achievement

Financial Responsibility

Waypoint Pediatric Therapies is committed to providing you with the best in care. If you have medical insurance, we are happy to assist you in receiving your maximum allowable benefits. It is the patient/parent/guardian's responsibility to know what their insurance will or will not cover. If your insurance provider and/or insurance coverage should change while receiving services, please notify us immediately in order to avoid lapse in coverage. If you fail to notify Waypoint Pediatric Therapies of a change, you will be responsible for any unpaid claims. This may also cause your personal information to be sent to the wrong organization which can lead to lapse in privacy.

By signing this disclaimer, you accept responsibility for payment of all expenses that are not covered by benefits under your insurance.

- I certify that I/my dependent has insurance coverage with a previously determined insurance company, and I authorize all benefits to be assigned directly to Waypoint Pediatric Therapies.
- I understand I am responsible for all charges that are not payable by insurance (including deductible, coinsurance, and co-pay) and any balance remaining.
- I understand that it is my responsibility to check with my insurance to determine and verify my benefits. I realize that Waypoint may have verified this but it is not a guarantee of benefits or payments.
- I also authorize the release of medical and billing information to my insurance company and physician as necessary.

INITIAL _____

HIPAA

I have received a copy of Waypoint Pediatric Therapies HIPAA (Health Insurance Portability and Accountability Act) and Privacy Polices.

INITIAL _____

Consent to Treat

As the child's parent and/or legal guardian, I hereby consent to necessary evaluations, procedures and/or treatments recommended by my child's therapist as necessary in his/her judgment. I understand that my child is under the care and supervision of my therapist. I also grant permission to my child's therapist for emergency care in the event that I cannot be reached.

I also understand that Waypoint Pediatric Therapies supports the higher education of physical therapy and pre-physical therapy students. Students may at times observe the treating therapist or assist and participate in the ongoing therapy afforded to your child at Waypoint Pediatric Therapies.

INITIAL _____

Photo/Video Release

I, (print name)_____, parent or official guardian of (child's name)_____hereby grant permission to Waypoint Pediatric Therapies and/or their representatives, to take and use: success stories, photographs, video, and/or digital images of my child for use in marketing or educational materials. These materials may include printed or electronic publications, Web sites or other electronic communications. I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Waypoint Pediatric Therapies.

INITIAL _____

Consent for Electronic Communication

Waypoint Pediatric Therapies uses various forms of electronic communication to stay in contact with our patients and their families. Some of those include email, cell phone and texting. Please let us know which of these forms you agree to, or if you decline electronic communication, please list your preferred method of contact.

Approve communication via email **INITIAL _____**
Approve communication via cell phone **INITIAL _____**
Approve communication via texting **INITIAL _____**

I **decline** the above use of electronic communication:

I prefer to be contacted via:_____

INITIAL _____

Waypoint Pediatric Therapies Cancellation, "No Show" and Late Arrival Policy

Waypoint Pediatric Therapies strives to provide the highest quality of care while meeting the needs and schedules of your family. We attempt to accommodate every child/family and provide reserved time spots for each of our patients to ensure continuity of your treatment. Consistent and timely attendance is necessary to achieve the goals established for your child.

Frequent, late cancellations and no-shows reduce our ability to follow through on your child's care, and to accommodate the scheduling needs of other patients. We are a small business, and these infractions significantly impact our ability to meet the needs of our patients. To give the best possible care to as many people as we can, we have developed the following policy.

Appointments are in high demand. **Please cancel your PT appointment at least 24 hours in advance**. A "Late Cancel" is a cancellation that occurs less than 24 hours prior to your appointment. A "No Show" is failure to notify us of your cancellation. Our scheduling staff will work with you to reschedule a cancelled appointment.

We understand that special circumstances arise, last minute illnesses occur, and flexibility is important. We therefore allow 2 late cancels/no shows prior to enforcing our penalty. We also offer additional flexibility as we will NOT count the no show/late cancel if you are able to reschedule that appointment (a make-up visit) within 1 month of the infraction. **After 2 late cancels/no shows you will lose your recurring spot and we will move you to our flex schedule**.

Chronic Cancellations or falling below a 75% attendance rate, will result in a change to flex scheduling.

Flex schedule will allow you to call in and book an appointment one week at a time so that it fits your schedule for that week. Please note that we cannot guarantee therapist/location/time when we move you to a flex schedule. At Waypoint, we collaborate regularly as a team and can ensure that each therapist will be prepared for your child's treatment.

There are many different frequency and scheduling options available if you are finding it difficult to comply with your current schedule, PLEASE discuss options with your therapist.

If you are more than 10 minutes late for a scheduled appointment, the delay requires us to bill your insurance for a shorter session than we had scheduled. As a small business, late arrivals impact the health of our practice significantly, in addition to limiting the progress of your child. We understand that some emergencies are not within your control and allow 2 late arrivals before moving you to a flex schedule. Late Pick Ups pose a significant liability issue for us as we do not have staff to ensure the safety of your child outside their therapy time. Please ensure that you arrive 5 minutes before the end of the PT session so that your child can be picked up on time. Late pick-ups will result in moving you to a flex schedule.

INITIAL _____

Waypoint Pediatric Therapies Illness Policy

We want to prevent the spread of illnesses and communicable diseases within our clinic!

We please ask that if your child or the caregiver accompanying your child to their appointment has had any of the following symptoms within 24-48 hours of their appointment that you please cancel your PT appointment:

- A fever of 100° or over
- Coughing, sneezing, runny nose, sore throat
- Vomiting, diarrhea
- Head lice or scabies

Exposure to COVID 19:

If you or your child had close contact with someone with COVID-19 please notify us. You may not need to quarantine if you and the child had confirmed COVID-19 within the last 90 days (meaning you tested positive using a viral test). If not, please cancel all visits for 5 days from date of exposure and get tested at least 5 days after you last had close contact with someone with COVID-19. If you test positive or develop COVID-19 symptoms, please follow guidance below. If you test negative, we can see you for an in-person visit as scheduled.

Positive COVID 19 Test:

Anyone with confirmed COVID-19 should stay home and isolate from other people for at least 5 full days (day 0 is the first day of symptoms or the date of the day of the positive viral test for asymptomatic persons). If you continue to have fever or your other symptoms have not improved after 5 days of isolation, you should wait to end your isolation until you are fever-free for 24 hours without the use of fever reducing medication and your other symptoms have improved. Contact your healthcare provider if you have questions.

Waypoint requires families with confirmed COVID 19 to provide a negative PCR test prior to returning to in-person visits. Some children may test negative but continue to have symptoms. Please call our office so we can guide you on next steps

Please contact scheduling@waypointpediatric.com, and/or call 425-270-3238 to reschedule your PT appointment.

I acknowledge and agree to the Waypoint Pediatric Therapies Illness policy.

INITIAL _____

Consent to Obtain or Release of Information

I authorize Waypoint Pediatric Therapies to obtain or release information regarding my son/daughter.

Name:_____DOB:_____

This information exchange is for the purpose of providing physical therapy. This includes providing treatment, procuring payment and conducting health care operations. I understand that to protect confidentiality of records, my agreement to obtain or release information is necessary. The information will only be shared as necessary to provide quality treatment and communication between healthcare, educational and payment providers. I understand that by written statement to Waypoint Pediatric Therapies, I may withdraw my permission at any time. This consent will be in effect throughout the duration of my child's treatment regimen. This consent applies to all physical therapists at Waypoint Pediatric Therapies who treat and/or have contact with my child.

NOTE: *Please be advised that we make every effort to maintain strict confidentiality of all our patients. However, due to our open concept clinic design, information about your child may be overheard.*

INITIAL _____

Permission granted to contact the following individuals, care providers, institutions:

_____
_____
_____
_____

INITIAL _____

Informed Consent for Telehealth Services

Name of Child	
Date of Birth	
Assigned Therapist	

You have chosen to receive care through the use of Telehealth. Telehealth enables health care providers at different locations to provide safe, effective and convenient care through the use of technology. As with any health care service, there are risks associated with the use of Telehealth, including equipment failure, poor image resolution and information security issues.

By signing this form, I understand the following: I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me/my child will be disclosed to anyone without my consent. The online connection used by Waypoint Pediatric Therapies meets required privacy standards and the only person present during treatment will be the child's authorized therapist. The therapist is in a private room during treatment and the screen cannot be seen by unauthorized people.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my child's care at any time, without affecting my right to future care or treatment.

I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Waypoint Pediatric Therapies has explained the alternatives to my satisfaction.

I understand that I may expect the anticipated benefits from the use of telemedicine in my child's care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, have discussed it with my therapist, and all my questions have been answered to my satisfaction. I hereby authorize Waypoint Pediatric Therapies to use telemedicine in the course of my child's treatment.

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NOTICE OF PRIVACY PRACTICES

Updated Date: January 2022

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how Waypoint Pediatric Therapies, Inc. may use or disclose your child's protected health information, with whom that information may be shared, and the safeguards in place to protect it. This notice also describes your rights to access and or refuse the release of specific information outside of this system except when the release is required or authorized by law or regulation.

Acknowledgement and Receipt of this Notice
You will be asked to provide a signed acknowledgement of receipt of this notice. The intent is to make you aware of the possible uses and disclosures of your child's protected health information and your privacy rights. The delivery of your child's health care services will in no way be conditioned upon your signed acknowledgement.

Who Will Follow This Notice
This notice applies to all therapy services provided by Waypoint Pediatric Therapies, Inc. It also applies to office personnel and billing personnel.

Our Responsibility Regarding Protected Health Information
Your child's protected health information is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your child's past, present, or future physical or mental health condition and related health care services. We are required by law to do the following:

- Make sure that your child's health information is kept private
- Give you this notice of our legal duties and privacy practices related to the use of and disclosures of your child's protected health information
- Follow the terms of the notice currently in effect
- Communicate any changes in this notice to you

We reserve the right to change this notice. Its effective date is at the top of this first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about your child as well as any information received in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the bottom of this page.

Our System
Waypoint Pediatric Therapies, Inc. works with several agencies and referral sources. Your child's health information may be shared in the following manner:

1. Treatment: We will use and disclose your child's protected health information to provide, coordinate, or manage your child's health care and any related services. This includes disclosure to your physician or other health care providers who become involved in your child's care.

2. Within our office for administrative activities, quality assessment, oversight, or peer review.
3. With billing personnel and as necessary to obtain payment for your health care services
4. With your insurance company or other payers as required for payment
5. With the referring agency and case manager, if applicable
6. With any other provider, school or agency with your written request. You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

Required by Law
We may use or disclose your child's protected health information if law or regulation requires the use or disclosure.

We will notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Legal Proceedings
We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Parental Access
We may disclose your child's protected information to parents, guardians, and persons acting in similar legal status.

Uses and Disclosures of Protected Health Information Requiring Your Permission
In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your child's protected health information.

If this service is provided in your home or other natural environments, those present during the session, including friends, family, or day care providers may hear health information regarding your child. Please notify your therapist if you do not want your child's protected health information to be discussed.

Your Rights Regarding Your Child's Health Information
You may exercise the following rights by submitting a written request to Waypoint Pediatric Therapies.

1. You may inspect and obtain a copy of your child's protected health information that is kept as a part of medical and billing records.

2. You may ask me not to use or disclose any part of your child's health information for treatment, payment, or health care operations. Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm your child.
3. You may request that we communicate with you using alternative means or at an alternative location. We will not ask you for the reason for your request. We will accommodate reasonable requests when possible.
4. If you believe that the information we have about your child is incorrect or incomplete, you may request an amendment to your child's protected health information as long as we are responsible for and maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.
5. You may request that we provide you with an accounting of the disclosures we have made of your child's protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. This disclosure must have been made after March 1, 2012 and no more than six years from the date of request. This right excludes disclosures made to you, or authorized by you, to family members or friends involved in your child's care. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this notice.

Federal Privacy Laws

This notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing policies and this notice of how we will use and disclose your child's protected information.

Complaints

If you believe these privacy rights have been violated, you may file a written complaint with the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

Updated January 2022