Waypoint pediatric therapies

Navigating a path to achievement

Family Contact Information

Child's name _____ ☐ M ☐ F

Date of Birth _____ Today's Date _____

Parent 1 Name _____ Parent 2 Name _____

Address _____ Address _____

City _____ State____ Zip_____ City _____ State____ Zip_____

Home #: (____) ____ - _____ Home #: (____) ____ - _____

Cell #: (____) ____ - _____ Cell #: (____) ____ - _____

Email: _____ Email: _____

Pediatrician/Primary Care Physician

Child's Physician_____ Phone_____

Referred by_____ Phone_____

Medical Diagnosis _____

Allergies _____

Employment Information

Parent 1 Employer_____ Parent 2 Employer_____

Occupation_____ Occupation _____

Phone_____ Phone _____

Emergency Contact

Name_____ Phone _____

Relationship_____ Alt. Phone_____

Insurance Information

Primary Insurance _____ Subscriber Name_____

Relationship_____ Subscriber DOB_____

Secondary Insurance _____ Subscriber Name_____

Relationship_____ Subscriber DOB_____

Please provide both insurance card and driver's license to photocopy

For Office Use Only:

ICD10: _____ _____ _____ _____

Case Title: _____

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Financial Responsibility

It is the patient/parent/guardian's responsibility to know what their insurance will or will not cover. By signing this disclaimer, I accept responsibility for payment of any and all expenses that are not covered by benefits of my insurance. I agree that if, for any reason, my insurance company fails to reimburse any portion of the claim for services, it is my responsibility to pay what is owed to Waypoint Pediatric Therapies.

I, the undersigned, certify that 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 after 60 days. **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.

Please note: If your child's 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.

_____ _____

Signature of Parent or Guardian Date

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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 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 _____

Cancellation Policy

As the child's parent and/or legal guardian, I have received Waypoint Pediatric Therapies Cancellation and "No Show" Policy. I understand that if I do not adhere to the cancellation or "no show" policy I will be charged a $50 fee for the missed appointment. I understand this is an out of pocket expense that **cannot** be billed to the insurance.

INITIAL _____

Patient Name_____

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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 **agree** to the above use of electronic communication:

_____ _____

Signature of Parent or Guardian Date

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

_____ _____

Signature of Parent or Guardian Date

I prefer to be contacted via:

_____

Patient Name_____