Milestone THERAPY

Today's Date: _____

Client Name: _____ DOB: _____

Mother Name: _____ DOB: _____

Father Name: _____ DOB: _____

Guardian Name: _____ DOB: _____

Address:

_____

_____

_____

Phone Number: _____ ☐ Home ☐ Cell

Alternate #: _____ ☐ Home ☐ Cell

Email Address: _____

Pediatrician Contact info:

Dr. _____

_____

_____

Type of Services: Requested: ☐ PT ☐ OT ☐ ST ☐ Other

Location of services: Indiana ☐ Clinic ☐ Home Illinois ☐ Other ☐ Home

Pediatrician Phone # _____

Pediatrician Fax # _____

Medical Diagnosis: _____ Script In Hand ☐ Needed ☐

Medications &/or Allergies: _____

How did you hear about us? ☐ Friend Internet ☐ Website ☐

Other: ☐ _____

Concerns to be addressed: _____

_____

Therapy Availability _____

Insurance Company Member ID: _____ Ins Co Group Number: _____

Ins Co Provider Services Number: _____

Primary Insured Name: _____ ***Fund*** ☐ Yes ☐ No

Milestone THERAPY

Primary Insurance: Date Called: Plan Verified ☐ Yes ☐ No

Spoke With: _____ Therapies Covered: ☐ PT ☐ OT ☐ ST ☐ Other

Effective Date: _____ Procedure Code Verified: _____ ☐ Yes ☐ No

Diagnostic Code/s Verified: _____ Location Codes Verified ☐ 03 ☐ 22 ☐ 11 ☐ 62 ☐ 12 ☐ 99

Deductible: Family _____ Individual _____

Met _____ Met _____

Out of Pocket: Family _____ Individual _____

Met _____ Met _____

Co-Pay: _____ Apply towards Deductible? ☐ Yes ☐ No

Copay Charge per ☐ Session ☐ Day

Needed for Therapy: ☐ Auth # ☐ Referral ☐ Nothing

Co-INS / % Call Reference Number _____

Total # of Visits: Combined Y/N Individual Remaining ____ Combined ____ IND

Claims Address: _____

Secondary Insurance: Date Called: Plan Verified ☐ Yes ☐ No

Spoke With: _____ Therapies Covered: ☐ PT ☐ OT ☐ ST ☐ Other

Effective Date: _____ Procedure Code Verified: _____ ☐ Yes ☐ No

Diagnostic Code/s Verified: _____ Location Codes Verified ☐ 03 ☐ 22 ☐ 11 ☐ 62 ☐ 12 ☐ 99

Deductible: Family _____ Individual _____

Met _____ Met _____

Out of Pocket: Family _____ Individual _____

Met _____ Met _____

Co-Pay: _____ Apply towards Deductible? ☐ Yes ☐ No

Copay Charge per ☐ Session ☐ Day

Needed for Therapy: ☐ Auth # ☐ Referral ☐ Nothing

Co-INS / % Call Reference Number _____

Total # of Visits: Combined Y/N Individual Remaining: ____ Combined ____ IND

Claims Address: _____

## Consent and Acknowledgement Receipt of Notice of Privacy Practices

As the child's parent and/or legal guardian, I hereby consent to necessary evaluation, 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. By signing this form, I acknowledge that I have received a copy of Milestone Therapy's Hippa and Privacy Policies.

I also understand that Milestone Therapy supports the higher education of students of Speech Language Pathology, Occupational Therapy, Developmental Therapy and Physical Therapy. Students may observe the treating therapist, assist and participate in the ongoing therapy afforded to your child by Milestone Therapy.

I am aware that there are programs that are available to me depending on my child's age that are provided by the state. I am electing to bypass those options, as applicable, in pursuit of private services offered by Milestone Therapy.

Milestone Therapy has separate copies of all policies for your availability, upon request. You can call us for a copy of any policy at 219-796-9335 or go to www.milestonetherapy.net

**INITIAL** _____

## Financial Responsibility

It is the client'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 a claim for services at this clinic, it is my responsibility to pay what is owed to Milestone Therapy. Please note that quotes obtained from verification is not a guarantee of coverage.

**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 Milestone Therapy 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 a lapse in privacy.**

**INITIAL** _____

## No Call/ No Show/ Late Arrival Policy

In an effort to provide effective and efficient treatment to all of our clients, it is the policy of Milestone Therapy that all appointment cancellations are to be made at least 8 hours prior to the scheduled appointment time.

If an appointment is not cancelled, prior to 8 hours in advance and client fails to attend their scheduled session Milestone Therapy reserves the right to charge the client a $25 fee, per occurrence. As this fee is not billable to any insurance company, the client accepts full responsibility to pay this fee.

If the client is more than 15 minutes late for an appointment, Milestone Therapy reserves the right to shorten the clients' standard appointment time as needed. In instances of a late arrival 30 minutes or greater, the client may be asked to reschedule. Should a client be required to reschedule due to a late arrival of more than 30 minutes, the client will be charged a $25 rescheduling fee.

Please contact us at **219-796-933**5 to cancel and appointment, or to let us know if you will be running late. If no one is available to answer your call, please leave a message stating your child's name, the day and time of appointment, your therapist's name and that you will be arriving late, or the reason you are canceling.

I understand that private payments for services are due in full at time services are rendered.

**INITIAL** _____

## Three Strike Policy

If your child's appointment is not kept due to a "no call / no show" or late developing situation - regardless of the reason, the missed appointment will be counted as a strike. After three strikes, Milestone Therapy reserves the right to stop providing services to the client.

If a family falls into a thrid strike, the therapist will establish a day and time for the folliwing session and contact the family a minimum of two business days prior to the established session date. If the family does not respond and confirm that date and time with the therapist by the end of business at 5:00 p.m. on day of contact, it will be considered a cancellation on the family's behalf and no services will be rendered to the child that week.

The **latest** a cancellation call is considered acceptable is 24 hours prior to the date and time therapy is to take place.

Milestone Therapy impliments this policy because it is in the best interest of the child to provide services for the child within the intevals set forth and due to the considerable difficulty for all parties to reschudule visits.

## Return Check & Late Payment Fees

Milestone Therapy will assign a $30 fee for all returned checks. I understand that I am subject to a $25 late fee for any payments received after 60 days of the invoice date. All accounts delinquent after 60 days will incur an interest charge of 1.5% monthly. Should my account become delinquent and be referred to any third party for collection efforts, I agree to pay all reasonable attorney's fees, court fees, and collection expenses.

**INITIAL** _____

## Infection Control Policy

All patients, or parents or guardians of patients, shall telephone to cancel and reschedule appointments when the patient may have one or more symptoms of a contagious disease. This will aid in the protection of the health of the staff, other patients, and family members.

Symptoms: Fever >100 degrees F, vomiting/nausea, open/draining lesion, lice, chicken pox, measles, productive cough, impetigo, conjunctivitis/pink eye, strep throat, diarrhea, any other contagious disease not listed.

**INITIAL** _____

## Photography and Video Release

I hereby authorize Milestone Therapy to photograph and/or video record my child for the purposes of treatment, education, and professional purposes. I also understand that my child may be in group pictures or videos that may also be reviewed by others outside of Milestone Therapy. I understand that if pictures of my child are used for advertisement or marketing purposes, Milestone Therapy will request consent from me prior to use of the pictures of my child. This authorization is valid for the duration of my child's therapy from the date signed below.

I understand that I make revoke this authorization at any time.

**INITIAL** _____

## Use of Electronic Communication

Milestone Therapy uses various forms of electronic communication to stay in contact with our clients. Some of those include email, cell phone and texting. If you choose to be contacted ONLY via home phone or postage mail, please initial below. Please be aware that postage mail communication will delay responsivness to ongoing therapy needs.

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

PARENT/GUARDIAN SIGNATURE: **X** _____

MILESTONE THERAPY WITNESS SIGNATURE: **X** _____