CENTER FOR
Pediatric
Rehabilitation

Record Number

ADMISSION & CONSENT

NAME OF PATIENT:_____

NAME OF PARENT / GUARDIAN:_____

DATE OF BIRTH: _____/____/_____ **AGE:**_____

HOME PHONE:_____ **CELL PHONE:**_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP CODE:**_____

EMAIL ADDRESS: _____

HAVE YOU PREVIOUSLY BEEN A PATIENT OF SPEECH & NEUROREHAB, INC./CENTER FOR PEDIATRIC REHABILITATION, INC.? ☐**YES** ☐**NO**

NAME OF PRIMARY CARE PHYSICIAN: _____

NAME OF REFERRING PHYSICIAN: _____

PRIMARY INSURANCE CARRIER:_____

SECONDARY INSURANCE CARRIER:_____

PLEASE HAVE YOUR INSURANCE CARD READY AS YOU CHECK IN SO A COPY CAN BE MADE FOR YOUR FILE– THANKS.

At this clinic, we evaluate, diagnose and treat disorders of language, articulation, fluency, pragmatics, feeding, swallowing, motor speech, voice, cognition, sensory processing, fine motor, and physical movement, etc. in pediatrics and adults in coordination with medical physicians. If you or your child is identified as having any degree impairment within the domains listed above, a formal diagnosis will be given, and treatment will be recommended. At that time a treatment plan will be generated which will be approved and signed by a medical physician. A copy of the evaluation and treatment plan will not be provided unless specifically requested. For us to communicate and coordinate with doctor offices as necessary, we require your permission to send and receive your personal health information in compliance with HIPPA and health information laws.

_____ I hereby consent to an evaluation which may result in a diagnosis and recommendation for treatment.
initial

I hereby consent to the Speech & NeuroRehab Center, Inc. and/or Center for Pediatric Rehabilitation, Inc. furnishing therapy services to me as prescribed by my physician. I hereby authorize payment directly to the Speech & Center, Inc. and/or Center for Pediatric Rehabilitation, Inc. of the individual or group insurance benefits specified and otherwise payable to me. I understand I am fully responsible to the Speech & NeuroRehab Center, Inc. and/or Center for Pediatric Rehabilitation, Inc. for all charges not paid by virtue of this assignment and they are authorized to release to said insurance companies any of my medical records.

_____ _____

Date **Patient or Parent's Signature**

THIS IS AN ELECTRONIC CLAIM FORM –
PLEASE ONLY SIGN THE BOX IN THE MIDDLE OF PAGE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

✸ **SIGN ONLY THIS BOX** ⬇

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CENTER FOR
Pediatric
Rehabilitation

Authorization for Release of Information

Name of Patient **Date of Birth**

Center for Pediatric Rehab, Inc. (CPR) and/or Speech & NeuroRehab Center, Inc. (SNR) is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. The checked entities are also authorized to release pertinent patient information to CPR/SNR as per patient's instructions.

ENTITY TO RECEIVE INFORMATION Check each method or person you approve in this column to receive information.	**DESCRIPTION OF INFORMATION TO BE RELEASED**
☐ Phone/Voice Mail	**This could include:** Financials, appointment date and times, etc.
☐ Encrypted E-Mail	**This could include:** Financials, appointment date and times, Evaluations and/or Plan of Care, correspondence from office or therapist, etc.
Family Members: ☐ Spouse _____ ☐ Guardian _____ ☐ Parent(s)_____ ☐ Other: Name: _____ Please note **exceptions** to receiving information: _____	**This could include:** Financials, appointment date and times, Evaluations and/or Plan of Care, correspondence from office or therapist, etc.
☐ Physicians/Hospital: _____ _____ _____	**This could include:** Financials, appointment date and times, Evaluations and/or Plan of Care, correspondence from office or therapist, etc.
Other Organizations: ☐ Provide Name: _____	This may include school system, day care, etc.

Patient Information:

I understand I have the right to revoke this authorization at any time and I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization. This authorization shall be in effect until revoked by patient.

A copy of the Privacy Policy at CPR/SNR regarding my Protected Health Information is available for me to read or take home.

Signature of Patient or Patient's Representative Date

CENTER FOR
Pediatric
Rehabilitation

POLICIES

Our staff works hard to offer you an appointment that is convenient for you or you and your child. We have policies in place to ensure the consistent quality of patient care and the smooth operation of our center.

NO-SHOWS or SAME DAY CANCELLATION POLICY

1) **First No Show or Same Day Cancellation:** The first time an appointment is not cancelled with a 24-hour notice or patient is a no-show, you will be called by your therapist or front office staff and reminded of policy. We will also work to reschedule the appointment.

2) **Second No Show or Same Day Cancellation:** The second time an appointment is not cancelled with a 24-hour notice or patient is a no show, you will be charged a $25.00 fee that is not covered by your insurance plan. ***You cannot be seen for subsequent appointments until the fee is paid.***

3) **Third and Final No Show or Same Day Cancellation:** The third and final time an appointment is not cancelled with a 24-hour notice or the patient is a no-show a letter will be sent to you and the referring physician and all future appointments will be cancelled.

We understand there will be times when you or your child may be sick. **If the patient is obviously sick please do not bring him/her to therapy until they are sufficiently well.** Rule of thumb for children: If they are too sick to attend school, they are too sick to attend therapy. We ask that after the third cancellation for sickness a note be provided from the primary physician.

We also understand that emergencies arise and that it may not always be possible to give 24-hour notice. These exceptions will be reviewed on a case by case basis.

Please understand that our policy is in place to assure we maintain a superior standard of care for all of our patients.

LEAVING THE PREMISES: If you must leave the premise during your child's session, please leave your phone number on the check-in sheet. Also, you must be back ***no later than 5 minutes before the end of your child's session*** so the therapist can give you your child's report for the day. **NO EXCEPTIONS**

DIAPERS AND CHANGING YOUR CHILD: We do not keep a supply of diapers and we do not change your child should they become soiled. You will be asked to change them so the session can continue. Please remember to bring a change of clothes with you to therapy.

PAYMENT:
Unless other arrangements have been made, payment is due at the time of service.

Signature of Patient or if under 18 Parent or Guardian **Date**

You will be given a copy of this policy page and Authorization for Release page