Sprout
PEDIATRIC THERAPY

pediatric patient form

Patient Identification

Patient's Last Name	First	Gender	DOB	Age

Home Address	City	State	Zip

Primary Care Physician	Additional Provider

Contact Information

Please provide names and the **BEST** possible phone number(s) and email. Be sure to notify us immediately of any changes. Please **CIRCLE** the email or phone that is the best way to reach you.

Parent(s)/Legal Guardian(s) Name(s)

1.____ Email____

Phone #_______________________________________ Phone # _______________________________________

2.____ Email____

Phone #_______________________________________ Phone # _______________________________________

Caregiver(s) Name(s) *People who might bring your child to therapy*

Name	Relationship	Phone Number

Name	Relationship	Phone Number

Emergency Contact Information:

Emergency Contact___________________________________ Relationship________________________________

Emergency Phone Number_____________________________ Phone Number 2 ____________________________

Insurance: *Copy of insurance card is required*

Primary Insurance ______________________________ Policy Number___________________________________

Group No.__________________ Effective Date ______________ Policy Holder's Name_______________________

Secondary Insurance_____________________________ Policy Number___________________________________

Group No.__________________ Effective Date ______________ Policy Holder's Name_______________________

Sprout
PEDIATRIC THERAPY

authorization/consent form

Patient Name____

Authorization for Treatment

I consent to the treatment necessary for the above named patient, including physical therapy, occupational therapy, speech therapy, aquatic therapy, massage therapy, and/or any other related services that the provider or physician advise to be necessary.

HIPPA Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Restrictions

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Individuals Allowed Access

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Cancellation/No-Show Policy – Please call 24 hours in advance to cancel.

We will send you a warning letter regarding your potential discharge after your 2nd missed visit. If there are 3 missed visits in a one-month period, you will be discharged from therapy. A letter will be sent to your primary care physician (PCP) explaining the reason for the discharge from our services. This will potentially cause a loss of your preferred time slot. In order to resume services you will need to obtain a new referral from your PCP and reschedule. We do understand there are special circumstances that can occur and we will review those carefully before making our final decision.

Payment/Insurance Authorization

I authorize for all insurance payments to be made directly to Sprout Pediatric Therapy for therapy services rendered. I acknowledge that I am financially responsible for all charges not covered by this assignment. I further acknowledge that my insurance company may limit therapy benefits. I will be responsible for all charges accrued if my insurance denies service. Thank you!

I have read and fully understand the above consent for treatment, release of medical information, and payment/insurance authorization. I have fully read and agree to the cancellation/ no-show policy as described above.

I request that payment under the medical insurance program be made to the provider named below on any bills for services furnished to me. I authorize the below-named provider to release to the Social Security Administration, its intermediaries or carrier's information needed for the claim or any related Medicare Claim. I acknowledge that I have read and understand the Medicare Authorization. I further permit a copy of this authorization to be used in place of the original.

Provider's Name: Sprout Pediatric Therapy
Provider's Address: 111 Arizona Ave NW, Suite 1, Orange City, IA 51041

____
Please Print (Patient or Parent/Guardian)

____
Signature (Patient or Parent/Guardian) Date

If signed by Patient representative, state relationship to patient____

authorization to release medical records

Records to be Released From/To

Business Name: **Sprout Pediatric Therapy**

Address: **111 Arizona Ave NW, Suite 1**

City, State, Zip: **Orange City, IA 51041**

Records to be Released To/From

Business Name____

Address____

City, State, Zip____

Patient Information

Patient Name____

Address____

City, State, Zip____

Date of Birth____________________________ Phone Number_____________________________________

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it;
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations;
3. I am entitled to a copy of this document;
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits;
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c) (4) (HIPAA);
6. This authorization shall expire upon my written request to revoke or according to state law;
7 A copy of this authorization is valid as the original.

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Signature of Patient or Patient Representative Date

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Description of Representative's Authority to Act for Patient