BACKWAY'S PHYSICAL THERAPY, PLLC: Pediatric Speech & Language Therapy
Insurance Client Information Form

Welcome to our Practice! ***Sorry these forms are lengthy****, but they will assist us in fully evaluating your child's condition and establishing a meaningful treatment plan. Please fill them in to the best of your ability.*

PATIENT's NAME______________________________**AGE**_____**BIRTHDATE**__________**HT**_____**WT**_____**SEX**____

Parent / Guardian Information

NAME 1 ____ **NAME 2** ____

Address ____**CITY**________________**STATE**_____**ZIP**_________

Phones: Home_______________________ **Work**____________________ Ext______ **Cell** ______________________________

Email: ____**PARENT'S MARITAL STATUS**: S M W D Sep.

CHILD's SOC. SEC. #______-_____-________ **BILLED UNDER SOC. SEC. #**______-_____-________

EMERGENCY CONTACT: Name: _____________________________________**Phone#**______________________________

DOCTORS' NAMES & PHONE #

1ST Dr.	2ND Dr.
Phone #	Phone #

Has your child received any physical therapy or speech therapy? ☐Yes ☐No

If yes, when? ________________________________ Please explain: ____

____

INSURANCE INFORMATION:

✶✶ Please be sure to bring your insurance cards and your picture ID with you. ✶✶ *The law requires that we copy them.*

HEALTH INSURANCE: *(Please write the Insurance Co. name, but only list the other information if it differs from your Card.)*

Primary Insurance Company Name:	**Secondary/Supplemental Insurance Company Name:**
Insured's Name:	**Insured's Name:**
Insured's Date of Birth:	**Insured's Date of Birth:**

RESPONSIBLE PARTY (Person responsible for paying the bill)

Name____ Relationship to patient __________________________________

Address____Zip_____________

HomePhone#______________________________WorkPhone#__________________________Ext_____________________

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We believe that parents & patients who understand and participate in their health care will achieve the best results. We respect your individuality, your rights, and your privacy, and we will give you the best care we possibly can.
Please read the following, and sign below. [Page 7 contains further details on our Financial and Office Policies]

Financial Responsibility: You are responsible for paying your deductible and your co-pay/co-insurance at each visit. If you cannot afford to pay, you will be expected to set up, and adhere to, a payment plan. Late fees may be charged on overdue account balances if you miss making regular payments. A fee of $25 will be charged on bank-returned checks.

Missed Appointments: If you need to cancel an appointment, let us know before 8AM of the day prior to the scheduled appointment. If you cancel late, or if the patient does not attend the appointment, **you will be charged** a missed-appointment fee.

I have read the two statements above, and understand them. I hereby consent to treatment by Backway's Physical Therapy, PLLC.

Signed____**Date**______________________________

Printed Name ____

Pediatric Speech and Language Therapy: Initial Questionnaire: Present Problems

*It is important that you inform us of **ALL** medical/health conditions at your first appointment, and immediately inform us of any changes in your child's medical/health condition during your course of treatment.*

***The following forms** will tell us about your child's health conditions, medications, your insurance & contact information. Some of the forms ask for your signatures to give us permissions for billing, treatment, and communication purposes; and for signatures to indicate that you understand how insurance, our billing, and the Privacy Act (HIPAA) work.*

Please answer these questions to the best of your ability. If something is confusing, leave it blank.

Information About What Brought You Here:

How did you hear about our services? ____

In a few words, please state the overall problem that brought you and your dependent to Speech Therapy:

____

Now give us more detailed information about your dependent:

Social Environment

1. Child lives with: ☐ both parents ☐ mother ☐ father ☐ siblings (how many ___) ☐ other _______________
2. Child's primary language:____
3. Any other languages spoken in the home ____
4. Name of school and current grade: ____
5. Any problems or concerns at school? ____

Speech/Language Concerns

1. Do you feel your child has difficulty communicating? Yes ☐ No ☐
   If yes, please describe in detail: ____
2. When did the communication difficulties begin? ____
3. Has the child had a hearing test? Yes☐ No☐
   If yes, when was the test and what were the findings? ____________________________________
   ____
4. Has the child ever had a speech/language evaluation? Yes ☐ No☐
   If yes, when and where was the evaluation? ____
   What were the findings? ____
   ____
5. Has the child ever received speech/language therapy? Yes ☐ No☐
   If yes, when and how long was the course of treatment? _________________________________
   ____
6. Are there any other concerns about the child's development? Yes ☐ No☐
   If yes, please describe: ____
   ____
7. Does the child exhibit any physical or emotional difficulties? Yes ☐ No☐
   If yes, please describe: ____
   ____

Patient name: _________________________________ Date: ____________

8. Does the child become agitated or frustrated because of lack of communication skills? Yes ☐ No ☐

Please describe any other behavioral issues: ____

Birth History

1. Was the pregnancy free of complications? Yes ☐ No☐

If no, please describe: ____

____

2. Was the child born full-term? Yes ☐ No☐

If no, how many weeks? ____

Please describe any issues or concerns: ____

____

3. Was the child discharged with the mother? Yes ☐ No☐

If not, please describe why, and the length of hospital stay: ______________________________

____

4. What was the mother's age when the child was born? ______________________________

Medical History

1. Has the child had any of the following?

☐ Adenoidectomy	☐Ear infections	☐ Allergies	☐Seizures
☐Tonsillectomy	☐Ear tubes	☐Asthma	☐Head injury
	☐Thumb sucking habit	☐Sleeping difficulties/Snoring	☐ Complications at birth

2. Please describe in detail any other issues you feel are pertinent to today's visit.

____

____

3. Please describe any other serious injury, surgery, hospitalization, or ongoing medical conditions:

____

____

____

4. Please list any known allergies: ____

5. Please list any other physicians or therapists involved in your child's care:______________________

____

____

Developmental History

1. Please give the approximate age at which your child achieved the following milestones:

Sat Alone _____________ Walked ______________

Babbled ______________ Said first words _________

Put two words together ___________ Spoke in short sentences _____________

2. Does the child:

Understand you? Yes ☐ No☐

Follow simple directions? Yes ☐ No☐

Patient name: ________________________________ Date: ____________ *(PedST: Insurance Initial Forms Page 3 of 7)*

Make wants/needs known using words? Yes ☐ No ☐
Respond appropriately to yes/no questions? Yes ☐ No ☐
Communicate with gestures? Yes ☐ No ☐
Become frustrated easily? Yes ☐ No ☐

Swallowing History

1. Please describe the nature of the swallowing problem(s):____
   ____

2. When did the problem(s) begin:____

3. Has the problem improved at all since it began? Yes ☐ No ☐
   If yes, please explain: ____
   ____

4. Does the problem(s) only occur with certain foods or liquids? Yes ☐ No ☐
   If yes, please list which foods or liquids:____
   ____

5. Does the problem(s) present only at certain times of day? Yes ☐ No ☐
   If yes, please explain: ____
   ____

6. Has the patient had a video swallowing study? Yes ☐ No ☐
   If yes: when and where? ____
   What were the findings? ____
   ____

Thank you *for providing this information for us. Please, let us know of any health changes.*

Magnitude of Symptoms:

Please indicate on the scale below the magnitude of your child’s problem(s):

0 1 2 3 4 5 6 7 8 9 10

◆────────────────────◆

None Mild Moderate Intense Severe Intolerable

Goals:

What results do you want from Pediatric Speech Therapy? ____
____
____

Backway's Physical Therapy: Intake Form *Pediatric Speech Therapy:* Patient Medication List

Please look at the labels on your child's medications & supplements; then list them below. This includes all prescription, over-the-counter, herbals, vitamins, minerals and dietary/nutritional supplements your child takes routinely, and/or on an as-needed basis.

Medication or Supplement Name	**Dosage**	**How many times/day?**	**Is this taken by mouth or other route?**	**What condition is this for?**	**"May cause dizziness" label on it?**	**Does this med make you dizzy?**
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Therapist notes: Is form complete? ☐ Yes, ☐ No. If no, reason not completed: ☐ Pt refused ☐ Emergency ☐ Pt cog unable **(initials: ________)**

Patient Name: ________________________ **Date:** ______________

Backway's Physical Therapy, PLLC **AUTHORIZATIONS & CONSENTS FORM**

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. ____________ (please initial)

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Optional**: Consent for Use of Information for Presentations, Research and/or Publications (optional)**
I grant permission, now and in future, to Backway's Physical Therapy, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education, research and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. My signing of this authorization is **not** a condition to receive treatment by Backway's Physical Therapy personnel.

(Optional) Patient's/Guardian's Signature ________________________________Date ____________

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All Authorizations below are Mandatory:

Authorization for release of information to Insurance Company & for payment from Insurance:
I authorize the staff of Backway's Physical Therapy to release information acquired in the course of my dependent's evaluation and treatment to the insurance company as needed to determine the benefits payable for the related service; and I request that any payment of authorized insurance benefits be made on my behalf to Backway's Physical Therapy, at their business address, for all services furnished that were not paid in full by me at the time services were rendered. **(_____ initials)**

Authorization for "Signature on File:" I authorize the staff of Backway's Physical Therapy to submit completed claim forms to the insurance company using the notation "signature on file" to indicate that I have signed this Authorizations Form. This one-time signature is valid for claims resulting from this and future services provided my dependent by Backway's Physical Therapy, PLLC. **(_____ initials)**

Authorization to leave Messages: In the event that Backway's Physical Therapy cannot speak to me in person regarding the appointments or evaluation results, I give permission to Backway's Physical Therapy to contact me and leave a message on *(check all that apply)*: **(_____ initials)**

Answering Machine ___________ Cell Phone ____________ or other location____________________

Consent for Mutual Exchange of Information: I authorize the mutual exchange of information regarding my dependent, between the Backway's Physical Therapy staff members, and all professional practitioners involved in the healthcare of my dependent, at any time (i.e. doctor, chiropractor, counselor, etc). Your office may also talk with the non-practitioner persons listed below about my dependent's health information: **(_____ initials)**

☐ Guardian 1	Name:	phone#:
☐ Guardian 2	Name:	phone#:
☐ Teacher	Name:	phone#:
☐ Other	Name:	phone#:
☐ Other	Name:	phone#:

Consent for Treatment: I hereby authorize the professional staff of Backway's Physical Therapy to evaluate and treat my dependent. During the course of evaluation and treatment, I authorize the licensed personnel at Backway's Physical Therapy to use any and all techniques they have been trained to use, which they believe will benefit my child, in order to help them recover. I have the right to refuse a specific technique or form of treatment, if I so choose. **(_____ initials)**

Receipt of HIPAA Patient Privacy Notice: My signature below indicates that I have received the HIPAA Patient Privacy Notice. I consent to your use and disclosure of protected health information about my dependent for treatment, payment, health care operations, and/or as required by law and by HIPAA. **(_____ initials)**

➔ **Guardian's Signature** _________________________________ Printed Name________________________

Patient name: _______________________________ Date: ____________

Backway's Physical Therapy, PLLC **FINANCIAL, BILLING & OFFICE POLICIES**

At Backway's PT, we are committed to assisting you, even with billing your insurance company. It is important that you realize **our relationship is with you, *not*** your insurance company. *Please* read these financial, billing and office policies to understand what we expect from you in this process; then sign below.

1. **Insurance:** We participate with most insurance plans, but not all of them. Each insurance company has many different plans, so we cannot know exactly what your plan covers. Therefore, it is **your** responsibility to know your insurance benefits. If you don't know, please call your insurance company and ask: What are my benefits for Physical or Speech Therapy? What is my deductible & has any been met? What restrictions or limits apply to my care? What is not covered? What is my copayment amount or coinsurance percent?
2. **Insurance Verification:** ***As a courtesy***, we call your insurance company to verify your insurance coverage. However, all insurance companies tell us the information they give us is "an estimate and is not a guarantee of coverage or benefits." Since your insurance company does not take responsibility for the information they provide to us, we cannot be sure of your coverage until they **actually process** your claim. ***Because of this***, **we cannot guarantee** payment of claims by your insurance company.
3. **You are responsible**. You are responsible for making sure your account is paid in full. Filing of all insurance claims, other than Medicare, is a **courtesy** provided by this office. We will assist you in any way we reasonably can to help get your claims paid. If your claim is reduced or denied by your insurance company, or you exceed your limits of coverage, you will be responsible for paying the balance on your account, up to your insurance company's normally allowed amount.
4. **Non-covered & Disallowed services:** Many health insurance companies do not allow or pay for supplies & maintenance services. Additionally, unbeknownst to us, in some rare cases, a portion, or all of the services you receive may not be covered or may be considered "not reasonably necessary" by your insurance plan. Because of this, we will bill you, and you agree to pay for services and/or supplies which may be denied as "non-covered" by your insurance plan.
5. **Payment is due at time of service**.

   ✶*Cash, check & credit card payments accepted with an added fee for use of a credit card.* ✶

   Credit Card payments are accepted for $50 or more, and are subject to an added $5 PayPal fee.

   You are responsible for paying your deductible, co-payment or coinsurance amount at the time of service. This arrangement is part of your contract with your insurance company.

   If you do not have sufficient funds to pay at the time of the visit, we expect payment to be made within 10 days of the visit, ***whether or not you receive an invoice from us.***

✶ ✶ ***If you have financial problems that affect your ability to make timely payment on your account***, please discuss this with us before or at the time of service, so that you can make payment arrangements. ✶ ✶

6. **Overdue Accounts**: All overdue accounts are subject to late fees. Amounts billed to your insurance company are considered overdue 30 days after they process a specific service date (even if this processing did not result in payment for that service date). Liens start accruing fees 90 days after discharge from therapy.

   Late fee tabulation:

Past Due Balance	$20 - $100	$101 to $750	$751 to $3000	Greater than $3000
Monthly Late Fee	$15	$25	$50	$75

   Returned check fee: A fee of $25 is charged on all returned checks.

   Collections: Returned checks and failure to pay account balances overdue for 90 days may result in our referring your account to an outside collection service.

7. **Missed appointments:** this policy was already stated at the bottom of page 1.
8. **We may refuse service** to a client under certain circumstances. Refusal is usually due to, but is not limited to: non-payment of past accounts; repeated missed/canceled appointments; inappropriate or belligerent behavior; and the therapists' opinion that our services won't benefit a client or aren't medically necessary.

I have read and understand the financial, billing & office policy information presented above.

Signed______________________________________ Printed Name ________________________________

Patient Name: __________________________________Date _________