First Step
Pediatric Therapy

Patient and family contact information:

Patient Name: _____ Sex (circle one): M F

Date of Birth: _____

Parent/Guardian 1
Name: _____
Address: _____
City: _____ State: _____
ZIP: _____
Phone: (_____)_____
Email: _____
Occupation: _____

Parent/Guardian 2
Name: _____
Address: _____
City: _____ State: _____
ZIP: _____
Phone: (_____)_____
Email: _____
Occupation: _____

Medical:
Pediatrician/primary care physician: _____ Phone: (_____)_____
Referring physician (if different from above): _____Phone: (_____)_____
Diagnosis (if known):_____

Emergency contact:
Name: _____ Phone: (_____)_____
Relation to your child: _____

Insurance:
Primary Insurance: _____ Subscriber name: _____
Relationship to Subscriber: _____ Subscriber DOB: _____
Group number: _____ ID number: _____

Secondary Insurance: _____ Subscriber name: _____
Relationship to Subscriber: _____ Subscriber DOB: _____
Group number: _____ ID number: _____

How did you find us?
_____ Google
_____ Facebook or Instagram
_____ Friend/word of mouth
_____ Physician recommendation
_____ Other: _____

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Consent to Treat:
As the patient's parent and/or legal guardian, I hereby consent to evaluations, procedures and/or treatments in accordance with the plan of care deemed necessary by the provider. I assume full responsibility for my child's participation in the services and activities within the recommended plan of care. I understand that I may at any time request further clarification on the activities, procedures, and services provided at First Step Pediatric Therapy before, during, or after my child's participation.

Signature: _____ Date: _____

Notice of Privacy Practices:
While providing services to our patients, we create, receive and store personal health information. We use and disclose your health information for treatment, payment, or health care operations. The Notice of Privacy Practices describes these uses and disclosures in detail. I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices from First Step Pediatric Therapy.
Please see full Notice of Privacy Practices in a separate from sent with paperwork

Signature: _____ Date: _____

Financial Disclaimer/Liability and Billing:
While we attempt to verify your insurance plan for services prior to your appointment as a courtesy, it is the responsibility of the parent/guardian to verify insurance eligibility and benefits, and facilitate referrals before your child's appointment. Your insurance carrier will determine final benefits after claims are processed. I understand all account balances and copayments are due at the time of service and I am responsible for all balances after insurance processing. All balances not paid within 30 days will incur a late charge of $10 per month. Balances not paid within 120 days may be forwarded to a collection agency and incur a $50 processing fee. There will be a $25 service charge for any returned checks. **Patients with a balance over $500 will be required to make a payment towards the balance, or set up a payment plan before continuing therapy.**

We send out invoices at the end of each month for any balances and copayments due. Would you prefer your invoice be sent to you as:

- Mailed invoice_____
- Emailed invoice_____
- Both_____

We ask that you please notify First Step Pediatric Therapy of any changes to your child's insurance carrier or coverage immediately while receiving services. I understand I am responsible for payment of any unpaid claims due to failure of notifying First Step Pediatric Therapy of insurance changes in a timely manner.

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I understand and acknowledge First Step Pediatric Therapy's financial policy and authorize First Step Pediatric Therapy to release any information necessary for insurance processing and authorize my insurance to pay First Step Pediatric Therapy directly.

Signature: _____ Date: _____

OPTIONAL: Billing Autopay
As a courtesy, First Step is now offering a bill autopay option.

(circle one) Credit / Debit

Cardholder Name: _____

Billing Address:_____

Credit Card Number: _____

Expiration Date: _____

Card Identification Number/ CVV (last 3 digits located on the back of the credit card): _____

I authorize First Step Pediatric Therapy to charge my credit card herein, month on the 1st of each month (or first business day of the month) to pay for the balance in full for therapy services rendered to my child including co-pay or co-insurance, deductible, private pay charge for services if any and other fees if proper cancelation procedures are not followed as per the signed cancelation policy.

I understand that the above authorization will remain in effect until the designated expiration date or until I cancel it in writing, whichever comes first, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Copies of the bills and receipts for payment will be available in your patient portal and can be accessed at any time.

Signature: _____ Date: _____

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Consent for Electronic Communication:
First Step Pediatric Therapy utilizes email and/or text communications, which are non-encrypted. I understand that there are risks to sending and receiving treatment information, scheduling reminders and other matters related to First Step Pediatric Therapy using non-encrypted methods. By signing below I consent to non-encrypted email communication.

Signature: _____ Date: _____

Cancellation Policy:
As a courtesy to our staff, we ask that you please read and adhere with our no show, late cancel, and late policies. These fees are an out-of-pocket expense and cannot be billed to insurance:

- In the absence of an illness, family emergency, or inclement weather, canceling or rescheduling an appointment must be made at least 24 hours prior to the start of your child's appointment. Patients will be billed a $40 late cancellation fee if cancellation is made less than 24 hours in advance.
- Patients who miss a scheduled appointment without providing the office advance notice will be billed a "No Show" fee of $75.
- Patients who are more than >15 minutes late to a scheduled appointment without advance notice will be billed a $20 late fee.
- Patients who "no show" to three consecutive appointments will be taken off of the therapist's ongoing schedule and must call weekly to schedule an appointment.

I acknowledge that I have read, understand, and agree to the policies above, and that I may ask questions about these policies at any point during my child's care.

Signature: _____ Date: _____

Inclement Weather Policy:
*Please see comprehensive *Inclement Weather Policy* in a separate from sent with paperwork*
To ensure the safety of patients and staff during adverse weather conditions, we have created a policy that can be referenced during extreme weather conditions. The following will only apply to in-clinic appointments, not aquatic therapy appointments.

When inclement weather conditions are anticipated or occur, patients scheduled for in-clinic appointments will be switched to a telehealth appointment. Families will be expected to attend their scheduled telehealth appointment in the event of inclement weather. Families are responsible for contacting First Step Pediatric Therapy via phone call or email if they do not have access to a camera, wifi connection, or hotspot.

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By signing below, I acknowledge that I have read, understand, and agree to the policies above, and will contact First Step Pediatric Therapy and that I may ask questions about these policies at any time.

Signature: _____ Date: _____

Sick Policy:
The safety and health of our children and staff is our priority, as many of our patients are very young and/or medically fragile.

If you, your child, or a family member in your household are experiencing any of the following symptoms, please call our office to cancel your appointment out of caution and courtesy to our staff and fellow patients. We can change your in-clinic visit to a virtual visit or reschedule your visit to a later date.

- Fever or chills in the past 24 hours
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

If you have tested positive for COVID-19, we ask that:

- You may return after 5 days if symptoms are no longer present or have significantly improved, or after receiving a negative COVID-19 test.

I acknowledge that I have read and understand the policies above, and that I may ask questions about these policies at any point during my child's care.

Signature: _____ Date: _____