Nelson Pediatric THERAPY

TEL 480.456.0719
FAX 480.456.0163

1930 E Southern Ave
Tempe, Arizona 85282-7518

Welcome to Nelson Pediatric Therapy!

We are pleased to provide physical, occupational and speech therapy services to children and adolescents throughout the State.

Thank you for asking us to provide therapy for your child. Please take a moment to fill out each of the enclosed forms and return them to us. The **Notice of Privacy Practices** sheet describes how health information about you or your child may be used and disclosed and how you can access this information. The **Patient Data** sheet provides information to the therapist(s) that treats your child. The **Insurance Information** and the **Insurance Letter** are used for billing purposes. Please complete the entire packet. **Also, please note that patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges to Nelson Pediatric Therapy**.

Treatment sessions are typically 1 hour in length and include direct treatment, training, consultation and documentation. Your child will benefit most from therapy sessions if you…

- Remain present throughout the entire session.
- Help us provide practical home programs you can do on a regular basis.
- Ask questions at the beginning of a session so we have time to discuss them with you.
- Have a quiet environment for therapy and minimize distractions (e.g. television, phone calls, siblings).

Important:

If you need to cancel a session, please notify us at least 24 hours in advance. Two or more no-shows or cancellations within a 4-week period may put your child at risk for being discontinued from our services.

We look forward to working with your family. ***Once the enclosed items are completed and returned to the office, the therapist will contact you to set up the start date***. Please note that we have a limited number of openings and a waiting list of children needing therapy, so we cannot promise you a time slot if the requested items are not returned **within 5 business days**. If you have any questions, please call us at the number shown above. We look forward to providing the therapy services that your child needs! Thank you.

Sincerely,

Cindy Nelson, PT

Cindy Nelson, PT

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review it carefully.

Our Commitment to Your Privacy

Nelson Pediatric Therapy is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide the following important information to you.

Your Rights Regarding Your Health Information

The health record we maintain and billing records are the physical property of Nelson Pediatric Therapy. The information in it, however, belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
2. Request that you be allowed to inspect and copy your health record and billing record - you may exercise this request by delivering the request in writing to the office;
3. Appeal a denial of access to your protected health information except in certain circumstances;
4. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
5. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
6. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
7. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and
8. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Cindy Nelson, PT, Privacy Officer at Nelson Pediatric Therapy in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Use and Disclosure of Your Health Information in Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and oversight agencies that are authorized by law to collect information;
2. Lawsuits and similar proceedings in response to a court or administrative order;
3. If required to do so by a law enforcement official;
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat;
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities;
6. To federal officials for intelligence and national security activities authorized by law;
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official; and
8. For Workers' Compensation and similar programs.

NOTICE OF PRIVACY PRACTICES
(Continued)

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location and about your general condition or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Right to a Copy of this Notice

You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give a copy of this Notice to you at any time.

Right to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with Nelson Pediatric Therapy or with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this Notice of Privacy Practices, please contact:
Nelson Pediatric Therapy
Attn: Cindy Nelson, PT, Office Administrator
1930 East Southern Avenue
Tempe, Arizona 85282-7518
480-456-0719

†By signing my name below, I hereby acknowledge that I have been presented with a copy of Nelson Pediatric Therapy's Notice of Privacy Practices.

†

_____ _____
Parent/Legal Guardian Signature Today's Date

_____
Parent/Legal Guardian Name (printed)

_____
Patient Name (printed)

PATIENT DATA

GENERAL INFORMATION

Today's Date: _____

Patient Name: _____ Birth Date: _____

Diagnoses: _____

My Child is... Biological: ☐ Foster: ☐ Adopted: ☐

Address: _____
Street Address City State Zip Code

Major Cross Streets Near Your Home: _____

Phone: _____ Phone: _____ Email: _____
cell: ☐ home: ☐ work: ☐ cell: ☐ home: ☐ work: ☐

Parent/Guardian (names/relationships): _____

Siblings (names/ages): _____

School (name/grade/teacher name): _____

Times Available (for Therapy) Mon: _____ Tue: _____ Wed: _____ Thu: _____ Fri: _____ Sat: _____

Primary Physician Name: _____ Physician Phone: _____

Physician Address: _____
Street Address City State Zip Code

DEVELOPMENTAL HISTORY

Perinatal History (complications before, during and/or after birth): _____

_____

_____

_____

Age at Developmental Milestones Roll: _____ Sit Alone: _____ Crawl: _____ Walk: _____

Mobility Status: _____

Feeding & Speech Status: _____

_____

PAST MEDICAL HISTORY

Previous Hospitalizations/Surgeries (type, date & doctor): _____

_____

_____

_____

_____

Orthotics/Braces (type, length of use): _____

_____

Medication Names: _____

_____

INSURANCE INFORMATION

Nelson Pediatric THERAPY

Patient Name:	Birth Date:	Age:	Sex:	SS #:
Address:	City:	State:		Zip Code:
Phone:	Diagnoses:			
Father:	Phone:	Mother:		Phone:
Referred By:	Support Coordinator Name:			
Primary Physician Name:				Phone:
Primary Medical Insurance Company Name:	Employer:			
Policy Holder's Name:	Birth Date:			SS #:
Policy Holder's Address (If different than Patient):	City:	State:		Zip Code:
Policy ID #:	Group #:			
Send Insurance Claims to:				Phone:
Insurance Mailing Address:	City:	State:		Zip Code:
Secondary Medical Insurance Company Name:	Employer:			
Policy Holder's Name:	Birth Date:			SS #:
Policy ID #:	Group #:			
Send Insurance Claims to:				Phone:
Insurance Mailing Address:	City:	State:		Zip Code:

† **MEDICAL INFORMATION RELEASE**

I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies or other health care agencies. I also authorize the release of medical records or copies of such and request that they be transferred to Nelson Pediatric Therapy, 1930 East Southern Avenue, Tempe, Arizona 85282-7518.

† **FINANCIAL POLICY**

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance. **Patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges**.

† **CANCELLATION POLICY**

If you need to cancel an appointment, we request a 24-hour notice. If you cancel within less than 24 hours of your scheduled appointment, you may be charged for ½ of the scheduled session. If you do not call to cancel and fail to keep your appointment, you will be charged for ½ of the scheduled session. **Insurance will not pay for "no shows" or late cancellation charges—these charges must be paid by the patient**. If you have 2 or more cancellations within a 4-week period, or 2 or more no shows, we reserve the right to discontinue services.

† **ASSIGNMENT OF BENEFITS**

I request that payment of authorized insurance benefits be made on my behalf to Nelson Pediatric Therapy.

†

Parent/Legal Guardian Signature

Today's Date

Parent/Legal Guardian Name (printed)

Patient Name (printed)

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INSURANCE LETTER

Dear Parents,

We are pleased to provide therapy services for your child. Please be aware that some insurance companies require that payments for therapy services be issued directly to the insured member and not to the therapy provider.

Please ensure that all checks you receive directly for services we provide are signed over and sent to Nelson Pediatric Therapy upon receipt. In the event that an insurance check is cashed accidentally, a personal check will need to be issued to Nelson Pediatric Therapy.

If you have any questions, please contact our billing department at 480-456-0719.

Sincerely,

Billing Department
Nelson Pediatric Therapy

† By signing my name below, I acknowledge receipt of this notification and will return a copy to the office. Thank you for your assistance in this matter.

†

_____ _____
Parent/Legal Guardian Signature Today's Date

_____
Parent/Legal Guardian Name (printed)

_____
Patient Name (printed)

Save Form Print Form Submit Form