Pediatric Therapy Network
Leading the way in helping children

Pediatric Therapy Network, LLC

NEW PATIENT INFORMATION

Child's Legal Name: _____
(First) (MI) (Last)

D.O.B:____/____/____ Age: _____ ☐Female ☐Male Home: (_____)_____

Home Address: _____

City/State/Zip: _____

Parent Email Address: _____

Parent/Guardian 1: _____ Cell/Work#: ( ) _____

Parent/Guardian 2: _____ Cell/Work#: ( ) _____

With whom does the child reside? _____

Emergency Contact Information: Please list who we may call in case of an emergency AND who may pick up the child from appointments and receive treatment progress information other than parent/guardian.

NAME: _____ PH#: _____ Relationship: _____

NAME: _____ PH#: _____ Relationship: _____

NAME: _____ PH#: _____ Relationship: _____

NAME: _____ PH#: _____ Relationship: _____

MEDICAL HISTORY:

Please list all your child's physicians/specialties:

NAME: _____ Specialty: _____

NAME: _____ Specialty: _____

NAME: _____ Specialty: _____

NAME: _____ Specialty: _____

What is your primary concern for having your child evaluated? _____

_____

Physical Address
1040 Southgate Corporate Park SW
Hickory NC 28602

Mailing Address
P.O. Box 1290
Hickory, NC 28603

P : 828.358.3115
F : 866.433.2198

Pediatric Therapy Network, LLC

Does anyone else have concerns about your child? (Family member, Physician, Teacher):_____

_____

_____

Does/has your child received therapy services (currently or in the past) through any other program/location? ☐ YES ☐ NO If yes, please list where and if current: _____

_____

Please list any medical diagnoses that your child has been given: _____

_____

_____

Please list any medications your child currently takes: _____

_____

Pregnancy/Birth History:

Birth Weight: _____ Weeks gestation: _____

Did child go home with family as expected? ☐ YES ☐ NO

List any problems or unusual stresses during pregnancy:_____

_____

_____

List any problems after birth (i.e: jaundice, required oxygen, etc): _____

_____

_____

List any medical problems during first few weeks of life, including hospitalizations:

_____

_____

_____

DEVELOPMENTAL MILESTONES:

Rolling		**Finger fed self**	
Get into sitting position		**Toilet trained**	
Sitting alone		**Dresses self**	
Crawling		**Eats with utensils**	
First Steps		**Walk alone**	
Spoke first word		**Put several words together**	

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HEALTH:

Has your child:

Had his/her hearing checked? ☐ YES ☐ NO Date: _____ Results: _____

Had his/her vision checked? ☐ YES ☐ NO Date: _____ Results: _____

Had their immunizations? ☐ YES ☐ NO Are they up to date? ☐ YES ☐ NO

Please list any allergies: _____

Are there any diagnosed medical, physical, or emotional problems? ☐ YES ☐ NO

Have there been any serious illnesses, injuries, or hospitalizations? ☐ Yes ☐ NO

If you answered yes to either of the above questions, please explain and give dates: _____

_____

_____

Daily Behavior/Communication:

Please describe if your child has any of the following:

Socializing problems: _____

Feeding problems: _____

Sleeping problems: _____

How does your child:

Get along with other children? _____

Let you know his/her needs? _____

Communicate with you? _____

Communicate with others (peers, siblings)? _____

Answer questions or respond to communication? _____

Talk about what he/she is doing? _____

Ask for help? _____

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OTHER:

What is your child's interest? _____

_____

Please list your goals for therapy (what you would like your child to achieve): _____

_____

_____

Please list anything else you would like us to be aware of: _____

_____

_____

Please let us know how we may contact you regarding appointments and your child's therapy:

☐ Home phone/voicemail:_____

☐ Cell phone/voicemail: _____

☐ Work phone/voicemail: _____

☐Email: _____

How did you hear about us? _____

_____ _____ _____

Parent/Guardian Printed Name Signature Date

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Parent or Legal Guardian Informed Consent for Services

I consent for my child to receive evaluation and/or therapy services from Pediatric Therapy Network and their treating therapists according to my child's physician's orders. I understand that Pediatric Therapy Network will bill my insurance company first. If the service is not covered by my insurance, I agree to pay for the service in-full immediately upon receiving a bill from Pediatric Therapy Network. If my child has NC Medicaid, PTN will accept the reimbursement as payment in full. I also understand that it is my responsibility to keep my child's insurance and/or Medicaid coverage in effect. I agree to inform PTN of any changes in my child's insurance coverage. I understand that if I do not keep my insurance or Medicaid coverage in effect, and do not inform PTN, I agree to pay the usual and customary fee for services provided during the period without coverage. If the below named child needs emergency medical care while receiving services, I give permission for PTN or their treating therapists, to obtain such care, and I agree to be financially responsible for the services.

Print Child's Name _____ Date of Birth _____

Parent or Legal Guardian Signature _____ Date _____

DIRECT ASSIGNMENT OF INSURANCE PAYMENT

Please bill my insurance:
When Pediatric Therapy Network files for third party insurance payment under my policy benefits, and they are otherwise payable to me as the policyholder, I authorize payment directly to Pediatric Therapy Network. If my policy prohibits direct payment to a doctor or treatment facility, the payment should be made to me as the policyholder, and I agree to reimburse the full amount to Pediatric Therapy Network. This is a direct assignment of rights and benefits under my insurance policy. Further, I agree to pay to Pediatric Therapy Network, in a timely manner, any balance that remains after payment of insurance benefits. A photocopy of this assignment shall be considered as effective as the original.

I have read and understand all of the above, and I agree to all of the conditions and information. I understand that this agreement will remain in effect the duration of treatment, and that I can revoke this agreement at any time in writing, except for services that have already been provided.

Policyholder/Legal Guardian Responsible for Payment _____ Date _____

Please bill me directly: ***(Sign the following section ONLY if you wish to be personally billed for services; otherwise leave blank.)***
I request that I, in accordance with the Health Insurance Portability and Accountability Act of 1996 ('HIPPA"), 45CFR 164.522 that Pediatric Therapy Network **NOT** contact my insurance carrier. In doing so, I understand the policy benefits will not apply to my charge for services and that **I WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICES. PLEASE BILL BE PERSONALLY AT THE TIME THAT SERVICES ARE RENDERED.**

Policyholder/Legal Guardian Responsible for Payment _____ Date _____

RELEASE OF INFORMATION

I authorize Pediatric Therapy Network, and/or their treating therapists to obtain/release information, as necessary, for the purpose of filling for insurance compensation or for requesting compensation from Federal or State resources that appropriate payment for services my child receives. I understand that in order for my child to be provided with the best possible services, PTN must have my permission to communicate with other providers involved in my child's care. I hereby grant permission for PTN and their treating therapists to obtain/share information with the following agencies/persons: ***(Please list the names of all physicians, practices, and agencies that are involved in your child's care)***

Primary Physicians/practice name: _____
Other Current Service Providers: _____
Physicians/Specialists: _____
Children's Developmental Services Agency (indicate which office): _____
Daycare: _____
Preschool Program: _____
School System: Current IEP Date: ****** Provide copy of current IEP to office staff***** _____
Previous Providers: _____

Parent or Legal Guardian Signature _____ Date _____

ACKOWLEDGMENT OF PRIVACY NOTICE/BALANCE BILLING and CLIENT PRIVACY RIGHTS

As a client of PTN, you have certain rights regarding your child's services and the protection of yours/your child's health care information.
"Notice of Privacy Practices" has been given to you today.
I have received a copy of the "Notice of Privacy Practices" and its contents have been explained to me in a manner in which I understand.

Parent or Legal Guardian Signature _____ Date _____

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New Intake 2022

Pediatric Therapy Network, LLC.

NOTICE OF PRIVACY PRACTICES AND CLIENT PRIVACY RIGHTS

Our Pledge to You

We understand that your child's health information is personal, and we are committed to protecting it. We create a record of the care and services your child receives at our organization. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about your child, describes your rights, and our duties regarding the use and disclosure of this information.

The **Health Insurance Portability and Accountability Act of 1996 (HIPPA),** *45 CFR Parts 160 & 164,* **The Confidentiality Law,** *42 CFR Part 2, and the* **NC General Statutes 122c** protect your child's healthcare information.

Under these Laws:

1. Our staff cannot acknowledge their professional relationship with you or your child to any person, including you family and friends, without your written authorization or one of the exceptions listed below.
2. We may not disclose any information identifying your child as a client, except as permitted by law.
3. We must obtain your written consent before we can disclose information to your health insurer/Medicaid in order to be paid for your child's services. *If you do not authorize us to release information to your insurance company, then full payment will be required at the time of service.*
4. We may use and disclose your protected health information for health care operations:
   a. Our office staff, clinical staff, and case managers are authorized to review medical records for the purpose of providing client care and treatment.
   b. Support staff and billing staff are authorized to review protected health information for the purposes of carrying out their routine jobs:
   c. Staff members conducting quality assurance, utilization review, and peer review activities may access protected health care information when they perform their review responsibilities.
   d. Students, interns, and trainees who have signed a confidentiality agreement with us and are working with PTN staff members to help them practice and improve their skills may also access information.

The law allows use and disclosure of information *without* your written permission:

1. When law requires the use and/or disclosure.
2. When it is necessary for public health activities.
3. We may share information with a physician who referred you to our agency.
4. We may share information with a business associate of PTN. (A business associate is one who provides services to PTN or provides services on our behalf.)
5. For research, audit, or evaluations.
6. To report a crime committed against our personnel.
7. To medical personnel in a medical emergency.
8. If we believe you are a danger to yourself or to others, or if we believe that you are likely to commit a crime, we may share information with law enforcement.
9. To appropriate authorities to report suspected abuse or neglect.
10. As allowed by court of law.

Written Authorization for Disclosure of Information

Before we can use or disclose any information about your health in a manner that is not described above or in items 1-10, we must first obtain your specific written authorization allowing us to make the disclosure. You may revoke any such written authorization in writing except for action has already been taken.

Contact Form Our Office/Your Child's Therapist

We may contact you to provide appointment reminders, billing clarification, assess the quality of our services, or other health-related benefits and services that may be of interest to you. IF you choose not to be contacted by us via telephone, letters, email, text, or messages, document you objection in writing, and give it to your service provider.

Our Duties

We are required by law to maintain the privacy or your child's health information, to provide you with a notice of our legal duties and privacy practices with respect to your child's health information, and to abide by this notice. If there are any changes made to the terms of this notice, we will provide you with the changes in writing. All PTN staff has been trained in maintaining your confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Client Privacy Rights

1. Under HIPAA, you have the right to request restriction on certain uses and disclosures of your health information. PTN is not required to agree to any restriction you request, but if we do agree, then we are bound by that agreement and may not use or disclose any information for which you have restricted, except as necessary in a medical emergency or as required by law.
2. You have the right to request that we communicate with you by alternative means or at an alternative location. We will accommodate such requests that are reasonable and will not request an explanation from you. For example: you may wish for us to call you at a different telephone number.
3. You have the right to inspect your record. Inspections must be scheduled with your primary provider and in some circumstances, requests may be denied. You also have a right to request a personal copy of your record for a fee. Pediatric Therapy Network must respond to your request within 30 days.
4. You have the right, with some exceptions, to amend healthcare information maintain in our records. All requests for amendments must be made in writing. Pediatric Therapy Network must respond to your request within 60 days.
5. You have the right to request and receive an accounting of disclosures of your health-related information made by PTN during the six years prior to your request (Not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following for your treatment, for billing and collection of payment for your treatment, for our health care operations, made to or requested by you or that you authorized, occurring as a result of permitted uses and disclosures, made to individuals involved in your care, allowed by law of if the information released did not identify you.
6. You have the right to received a paper copy of this notice.

Client Grievances

PTN provides a policy regarding client grievances and complaints: If you have a grievance that cannot be resolved with your therapist, you should document your grievance and forward it to Pediatric Therapy Network, Attn: Privacy Officer PO Box 1290, Hickory NC 28603. You may file a complaint with PTN and/or the Secretary of the United States Department of Health and Human Services if you feel that your privacy rights have been violated under HIPAA. If you file a complaint, we will not take any action against your or change our treatment of you in any way. To file a complaint with Pediatric Therapy Network, document your complain in writing along with your full name, address, and phone number and forward it to our privacy officer.

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have the following protections:

• You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

• Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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Pediatric Therapy Network, LLC

Cancellation/No Show Policy

Pediatric Therapy Network takes pride in our policy of scheduling only one patient at a time. Unlike other doctor offices who schedule 2 or 3 patients in the same time slot (which is why you generally wait 30-60 minutes to be seen), at our office your appointment time is reserved exclusively for your child.

CANCELLATIONS:

We would like to thank you for being a patient in our office. We value all our patients and strive to provide the best care possible. Please understand that when we schedule your appointment, we are reserving that time for your family's particular needs. We kindly as that if you must change an appointment, please notify us within **24 hours** of the scheduled appointment time. It is the policy of Pediatric Therapy Network, LLC to require clients to cancel via phone within **24 hours** of the scheduled time. If sick, you may call the day of the appointment, but must be **two hours** before scheduled appointment time.

Two or more consecutive cancellations without medical/excusable reasons will result in loss of your child's regular appointment time. Also, cancellations greater than 30% of the treatments in a 10-week period will result in loss of their standing appointment and they **will be suspended from our practice until they attend a cancellation/no-show class**.

NO SHOWS (Missed appointments/non-cancelled)

We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours (2 hours in the event of sickness) before the scheduled time.

Established patients who no-show for their scheduled appointment 3 times within a **one year period** will be suspended from our practice until they attend a cancellation/no show class.

You may call 24 hours a day to cancel your appointment. If you call to cancel an appointment after office hours, the answering service will take a message. Patients who arrive more than 10 minutes late for scheduled appointment are considered a "no show" and the therapist decides if their schedule permits seeing them.

First time no-show suspended patients must attend a one-hour cancellation/no show class. The cancellation/no show classes are typically offered every month. After attending a cancellation/no show class the patient is allowed back into the practice.

Further suspensions for repeated cancellation/no shows require a one-month suspension period. Then the patient can be scheduled to meet with the management or their designee to discuss this matter. If approved, and after signing a re-admittance agreement, they will be allowed to be scheduled.

By signing this form, I agree to cooperate with the cancellation/no show policy of Pediatric Therapy Network, LLC.

Thank you for choosing Pediatric Therapy Network to serve your child's needs.

_____ _____

Signature of Parent or Authorized Person: Date

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Pediatric Therapy Network, LLC

DATE: ____/____/____

Patient Insurance Form

Patient Information

First Name: _____MI: _____Last Name: _____

Date of birth:____/____/____ Social Security # (if Pt is self-responsible): _____

Primary Insurance Update

Primary Insurance Company: _____ Phone#: _____

Subscriber name: _____ D.O.B: _____/____/_____

Subscriber #: _____ Group #:_____ Employer: _____

Relationship to Patient: ☐Self ☐ Spouse/Partner ☐ Parent/Guardian ☐ Other

Secondary Insurance Update
(If Applicable)

Secondary Insurance Company:_____ Phone#: _____

Subscriber name: _____ D.O.B: _____/____/_____

Subscriber #: _____ Group #:_____ Employer: _____

Relationship to Patient: ☐Self ☐ Spouse/Partner ☐ Parent/Guardian ☐ Other

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: Pediatric Therapy Network, LLC

_____ _____ _____

Parent/Guardian Signature Printed Name Date

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Pediatric Therapy Network LLC

Pediatric Therapy for Children

Policy and Procedure Manual

REVISED 6/18/2021

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New Intake 2022

It is important that all patients read and understand this manual.

Welcome to Pediatric Therapy Network.

We provide a variety of therapeutic procedures designed to assist in deficits related to (but not limited to) hand skills, motor coordination, self-care and instrumental activities of daily living., sensory processing, feeding aversion, handwriting, and motor timing/control. Our primary focus is to promote independence for children in a fun and comfortable setting.

OFFICE HOURS: Hours vary depending upon summer or school year. Please check with the office to verify hours of operation.

In the event of inclement weather, a recorded message will be posted on our answering service informing clients of hours of operation. We will also post it on our social media pages as well. We will attempt to reschedule all missed appointments.

HOLIDAYS: The office is closed in observance of some holidays. All closings will be posted in advance.

ARRIVING/DEPARTING: When arriving or departing, please escort children to and from your vehicle as well as supervise your children in the waiting area. Upon arrival, please sign in and wait until your child is called back for therapy. Parents are always welcome to observe during therapy unless it impedes the outcome of therapy. Siblings are NOT allowed in treatment rooms and must be supervised in waiting area. If you need to leave, please return at least fifteen minutes prior to the session ending. You are responsible for your child when he/she is not in session. We ask that parents come inside to pick up your child. We will not escort a child outside to the vehicles. Your child's safter is very important to us!

CHANGES IN INFORMATION: To keep our records and billing up to date, please inform the receptionist of any changes.

CHILD ABUSE: If there is any abuse or neglect suspected, we are required by the law to report it to the Department of Human Resources.

DISCIPLINE: Our staff uses redirection as the primary form of discipline. If your child's behavior becomes unmanageable, we will ask for your assistance. If a parent or guardian is not on the premises, the therapist will remove the child from the situation to prevent harm to others and/or self. If necessary, bear hugs or deep pressure activities will be used to help calm the child. No restraints (e.g. belts, straps) are used on the premises. However, if a client uses a helmet and/or splinting devices to prevent injury, those are permitted. A parent or guardian must stay on premises during therapy for any child with a history of aggressive behaviors to others and/or self. If a client's behavior is unmanageable or a threat to others and/or self during therapy, the session will be discontinued, and future sessions will be authorized only after consultation with the parent/guardian.

ALLERGIES: Please inform the therapist and office of any allergies (environmental, drug or food). We use a variety of food for therapy, and it is vital that we have accurate records of any known allergens.

PRIVACY: All information regarding each child and family will be kept confidential. Any release of information must be accompanied with written permission by each client's parent and/or legal guardian. Pediatric Therapy Network, LLC follows all privacy policies in accordance with local and federal regulations.

APPOINTMENTS: Most children have regular appointment times. Please arrive only ten minutes early to reduce overcrowding in the waiting area. If you are going to be greater than 15 minutes late, please call and inform the office.

CLOTHING FOR APPOINTMENTS: We use a variety of sensory modalities and suggest that your child come in appropriate attire. Females should wear shorts or pants under any dress or jumper. Clothes that can get "messy" are recommended.

CANCELLATIONS: Please notify us if you are not able to keep your appointment. It is the policy of Pediatric Therapy Network, LLC to require clients to cancel via phone within 24 hours of your child's appointment time. If sick, you may call the day of the appointment, but must call as soon as possible. Three or more consecutive cancellations without medical/excusable reasons will result in loss of your child's regular appointment time. Also, cancellations greater than 30% of the treatments in a 10-week period will also lose their standing appointment. Weekly scheduling will be required after that time.

ILLNESS: Any child showing signs or symptoms of illness will not be seen for therapy. Your child must be fever free for 24 hours prior to their appointment without aid from medication. If any child shows these symptoms during therapy, they will be sent home immediately to allow for disinfection.

The signs and symptoms include: *sore throat *fever (100 degrees or higher) *diarrhea/vomiting *coughing *runny nose (except for allergies) *red/watery eyes with discharge *general malaise *skin rashes *any other communicable diseases.

HOME PROGRAMS: All children will be given home exercises and/or activities to complete at home. These programs will vary in amount and rate depending on the specific treatment needs of the child. Most children progress at an increased rate when these programs are completed at home.

STAFF: The educational and professional qualifications of all staff far exceed the necessary skills to practice. All have pediatric experience, and all continue to learn and improve their skills necessary to provide the best service available. Each child will have a primary therapist but may also be served by another therapist due to illness, vacations, or other conflicts. We believe strongly that it is important for your child to understand and learn to tolerate variations in life and that a change in therapist allows for greater objectivity. All staff are trained to help a child accept change in routine.

PHOTOS: You will be asked to provide permission or to refuse photos to be taken of your child. Photos are often used for resource fairs, brochures, or the web page. These photos will not be used without your permission. Videos during treatment may be taken to share only with parents to use as a teaching tool. In addition, we may at times, request videos from home to show mealtimes, behavior concerns, etc. These videos will be kept confidential as part of the treatment folder.

CAREGIVER/THERAPIST CONSULTATION: We allow time for the therapist to review treatment progress and home programs during the last 10 minutes of each treatment session. If the therapist has information, they believe is “sensitive” she will ask the parent to come back to the treatment room.

DISCHARGE FROM SERVICE: We enjoy and love working with all children and discharge from therapy brings joy and sadness. Our goal is to assist children with independent skills needed for life. Our services are based on medical necessity and must be accompanied by a physician's referral. Services are most typically discontinued for the following reasons:

1. Expiration of physician referral without renewal
2. The child has met treatment goals
3. The child has not met treatment goals, but progress is no longer measurable and skilled services are no longer showing documented change in performance.
4. The child's family request dismissal
5. Relocation of family

Our goal is to make discharge from therapy a positive experience for all children. As needed, we will provide assistance regarding additional community resources that may be helpful upon discharge.

GENERAL BILLING POLICY

Pediatric Therapy Network, LLC requires co - payment of all accounts at the time services are rendered unless arrangements have previously been made with the owner.

INSURANCE: Our office is "in-network" for the following insurance companies: Blue Cross/Blue Shield of NC, Tricare, Cigna, United Health, Med-Cost, Health Choice, Medicaid Managed Care & Medicaid Direct. Please check with our office if you have any questions about your insurance policy. This practice will bill predetermined insurance benefits and will allow a maximum of 45 days from billing submission for insurance to cover expenses. Should payment not be received, the client or responsible party will be billed for the total charge, and payment is expected upon receipt of the bill. **Clients are responsible for what insurance does not pay.**

BILLING POLICY FOR CLIENTS WITHOUT INSURANCE OR WITH PARTIAL INSURANCE COVERAGE:
Payment is due at the time service is rendered.

AMOUNT OF CHARGES: The total charges for services rendered and any insurance benefits are based on customary or reasonable rates for the same or similar procedural code.

PAYMENT METHODS: Cash, check, and most major credit cards

RETURNED CHECKS: A fee of $40 charge will be rendered for all returned checks.

INTEREST FEE: A 2% interest fee will be added to the amount due each 30 days after 60 days of the initial bill date.

RESPONSIBLE PARTIES: If more than one individual sign the agreement, their liability shall be joint and several. If an undersigned fails to make payment due hereunder, said account shall become delinquent and will be turned over to a collection agency or an attorney for collection. The undersigned hereby acknowledges and agrees that they shall pay all legal and associated collection fees. The undersigned hereby waive(s) all rights to notice presentment or demand by Pediatric Therapy Network, LLC.

ANY CHANGES TO THESE POLICIES WILL BE POSTED IN WRTTEN FORM OR PROVIDED DIRECTLY TO THE PARENT.

Please sign both signature lines. One will be for your records and one will be kept on file with Pediatric Therapy Network, LLC.

I have read and understand the above stated policies and procedures of Pediatric Therapy Network, LLC.

SIGNATURE: _____ **DATE:** _____

SIGNATURE: _____ **DATE:** _____

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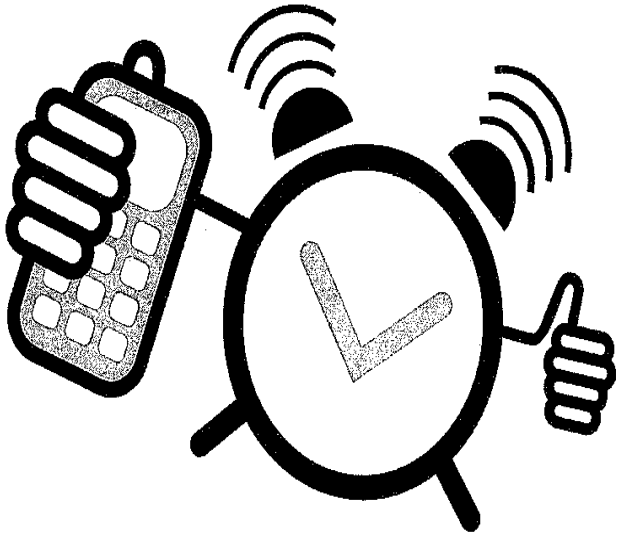
P.O. Box 1290
Hickory, NC 28603

P : 828.358.3115
F : 866.433.2198

Pediatric Therapy Network
Leading the way in helping children

Automated Appointment

Reminder Services:



Cell Phone # _____

☐ **Text**

☐ **Voicemail**

Home Phone #_____

☐ **Voicemail**

_____

Signature

Physical Address
1040 Southgate Corporate Park SW
Hickory NC 28602

Mailing Address
P.O. Box 1290
Hickory, NC 28603

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F : 866.433.2198

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Photograph and/or Video Consent

Name of Parent/Caregiver: _____

Child's Name: _____

Child's DOB: _____

☐I give my consent to:

- Be photographed or videoed.
- Allow the photograph/film to be edited and changed.
- Be mentioned in blogs, website, Facebook, Instagram, and other forms of social media.
- Be used for marketing materials as needed.

Pediatric Therapy Network will take all steps to ensure that images are used solely for the purpose for which they are intended.

☐I DO NOT give consent for my child to be photographed.

Signature: _____

Date: _____

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