



Client Information

Child's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Father's Name _____ Phone (home) _____

Phone (cell) _____

Address _____

City _____ State _____ Zip _____

Email _____

Father's Employer _____

Mother's Name _____ Phone (home) _____

Phone (cell) _____

Address _____

City _____ State _____ Zip _____

Email _____

Mother's Employer _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Care Physician _____

Address _____

Phone _____ Fax _____

Developmental/Health History

Who referred your child to therapy? _____

Has your child been given a diagnosis? yes no

If yes, what is the diagnosis? _____

Who made the diagnosis? _____

Is your child on any medications? yes no

Please list: _____

Birth History

Full Term yes no Premature yes no If yes, how many weeks? _____

Were there any complications during pregnancy? yes no

If yes, please describe.

Were there any complications during labor or delivery? yes no

If yes, please describe. _____

Vaginal ____ C-section ____

What was your child's birth weight? ____ lbs ____ oz

Developmental History

At what age did your child: Sit Alone _____ Crawl _____ Walk _____ Say single words _____ Put two words together _____

Has your child had his/her hearing checked? yes no

Pass Did not Pass _____

Has your child had his/her vision checked? yes no

Pass Did not Pass _____

Medical History

Does your child have a history of or currently experience:

Ear Infections	<input type="checkbox"/> yes <input type="checkbox"/> no	Tube Placement	<input type="checkbox"/> yes <input type="checkbox"/> no
Allergies	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Vision Difficulties	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Hearing Deficits	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Head Injury	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Major Illness	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Feeding Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	
Other medical history	_____		

Has your child been hospitalized? _____ If yes, for what reason?

Therapy Goals

What are your goals for therapy? _____



Insurance Information

Primary Insurance Company _____

Policy Holder _____ Employer _____

Relationship to Patient _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

ID or Policy # _____ Group # _____

Address to send claims to: _____

City _____ State _____ Zip _____

Insurance phone number () _____

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, third party payers, or other health care agencies. A photocopy of this assignment is considered as valid as the original. I also authorize the release of medical records or copies of such and request that they be transferred to Piller Child Development, LLC,

Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to Piller Child Development, LLC.

Signature _____ Date _____

Consent for Care

I, the undersigned, to hereby agree and give my consent for Piller Child Development to furnish medical care and treatment considered necessary and proper in diagnosing treating my physical condition.

Signature _____ Date _____



Payment Policies

Piller Child Development, LLC does everything possible to minimize the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is summary of our payment policy.

All payment is expected at the time of service

Payment is required at the time services are rendered. This includes applicable co-payments for participating insurance companies. Payment will be collected when you check in. We are unable to bill co pays to you or secondary insurances.

Outstanding Balance

Once payment is received from your insurance company, you will be billed for any remaining amount. Payment for outstanding balances is expected within 10 business days. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments. We realize that people have financial difficulty. Please communicate with our billing and collection staff so that they may assist to create a financial plan with you. If your account becomes delinquent, we will be forced to forward it to a collection agency. A fee of \$25 will be applied to each returned check.

Insurance

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductibles and co-payments at the time of service. If we have not received payment from your insurance company, you will be expected to pay the balance in full. You are responsible for all charges. Insurance cards must be provided at your first appointment. If your insurance company requires you to have a referral or authorization for therapy, please verify with our front office that a current referral or authorization is on file. Our office will put forth as much effort as possible to help obtain these documents, however, the **patient is ultimately responsible for any resulting costs that may be associated with your visits.**

Refunds

Overpayments will be refunded upon written request to the responsible party within 30 days of our office confirmation. Otherwise, overpayments will be applied as a credit to your account.

Missed Appointments /Cancellations

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24-hours notice to avoid charge. Cancellations with less than 24 hour notice, short notice reschedule, or “no shows” will be subject to a \$25 fee (\$50 for Saturday appointments). If you have more than 2 cancellations within a 4-week period or 2 or more “no shows,” we reserve the right to discontinue services.

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.

Signature _____

Date _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received a copy of Piller Child Development's Notice of Privacy Practices.

Parent or legal guardian signature

Date

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)

I authorize and agree that Piller Child Development may disclose my protected health information to the following persons, each of who is directly involved in my care: (Please list pcp, and other doctors or therapists that you would like to receive copies of reports)

Name	Relationship to Child	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge and agree that Piller Child Development may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Piller Child Development.

Piller Child Development may contact me via the following manners:

Phone yes no Leave Message yes no
Text Message yes no
Email yes no

Signature

Date

Printed Name



AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Parent Name: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider Piller Child Development, LLC to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information either in writing or verbally

Fax _____ Phone _____

Purpose: I understand that the specific purpose of this Authorization is

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

- All therapy records
- Evaluation only
- All therapy records except: _____

Term: This Authorization will remain in effect until _____.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Parent/Guardian Signature

Date