PILLER
CHILD
DEVELOPMENT

Client Information

Child's Name_____
First Middle Last

Date of Birth _____

Address _____

City _____ State _____ Zip _____

Contact Email _____

May we email you? ❑ yes ❑ no

Primary Phone _____

Alternative Phone _____

May we leave a message? ❑ yes ❑ no

Father's Name _____

Address _____

City _____ State _____ Zip _____

Father's Employer _____

Mother's Name _____

Address _____

City _____ State _____ Zip _____

Mother's Employer _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Care Physician _____

Address _____

Phone _____ Fax _____

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Developmental/Health History

Who referred your child to therapy? _____
Has your child received therapy in the past? ☐ yes ☐ no
☐ Speech therapy ☐ Occupational therapy ☐ Physical 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 ____ Toilet Trained ____
Babbled ____ Say single words _____ Put two words together _____

Has your child had his/her hearing checked? ☐ yes ☐ no
☐ Pass ☐ Did not Pass Date of Test _____

Has your child had his/her vision checked? ☐ yes ☐ no
☐ Pass ☐ Did notPass Date of Test _____

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Medical History

Does your child have a history of or currently experience:

Ear Infections ☐ yes ☐ no
Adeniodectomy ☐ yes ☐ no
Allergies ☐ yes ☐ no
Asthma ☐ yes ☐ no
Vision Difficulties ☐ yes ☐ no
Hearing Deficits ☐ yes ☐ no
Seizures ☐ yes ☐ no
Head Injury ☐ yes ☐ no
Major Illness ☐ yes ☐ no
Feeding Problems ☐ yes ☐ no

Tube Placement ☐ yes ☐ no
Tonsillectomy ☐ yes ☐ no
_____
_____
_____
_____
_____
_____
_____
_____

Other medical history _____
_____

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

Social and Academic

Who resides in the child's home? _____

Does your child attend school or preschool? ☐ yes ☐ no
If yes, what grade? _____
Does he/she perform at grade level in Reading ☐ yes ☐ no Math ☐ yes ☐ no
Does your child currently have an Individualized Education Plan (IEP) and/or receiving special services? ❑yes ❑no

Do you have any concerns with social skills? ☐ yes ☐ no If so, please describe
_____
_____
_____

What does your child like to do in his/her free time? _____
_____

Does your child have a favorite toy or something he/she enjoys (e.g. Thomas, cars, etc)? _____

Therapy Goals

What are your goals for therapy? _____
_____
_____
_____

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Insurance Information

Primary Insurance Company_____

Policy Holder _____ SS Number _____

Relationship to Patient _____ Date of Birth _____

Employer _____

ID or Policy # _____ Group # _____
Marketplace plan __yes ___no

Secondary Insurance Company_____

Policy Holder _____ Employer _____

Relationship to Patient _____ Date of Birth _____

ID or Policy # _____ Group # _____

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 evaluating and treating my physical condition.

Signature _____ Date _____

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

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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. We have a contractual obligation (with your insurance company) to collect all co-pays and co-insurance. This includes applicable co-payments for participating insurance companies. Payment will be collected when you check in. We are unable to bill co pays/coinsurance to you. Patients are encouraged to keep a credit card on file with the front office. This credit card will be charged on the date of service for all payments due.

Outstanding Balance
Once payment is received from your insurance company, you will be billed for any remaining amount and the credit card on file will be charged as indicated. Payment for outstanding balances is expected within 10 business days. Patients with an outstanding balance of 30 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 by more than 60 days, we will be forced to forward it to a collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee we charge you will be equal to the amount that the collection agency charges us. You will be responsible for paying the full balance, including this fee. 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.**

Missed Appointments /Cancellations/Late Appointments
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 $35 fee. “No show” on Saturday appointments are subject to a $50 fee. No show fees are automatically charged to the credit card on file. 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. If more than 15 minutes late to an appointment, we reserve the right to charge a late appointment fee of $15.

Initials _____

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.

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.

____ I understand that patient billing statements will be sent via email.

I agree to the terms of the payment and cancellation policy. My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

Signature_____ Date _____

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Credit Card Authorization Form

I, _____ , hereby authorize Piller Child Development, LLC, to charge my credit card for the amounts invoiced/payments due.

Patient Name: _____

AMERICAN EXPRESS / DISCOVER / VISA / MasterCard only

Credit Card Number:
_____

Expiration Date: _____ /_____ SEC Code: _____

Credit Card Billing Address:
Street: _____
City:_____State: _____Zip Code: _____
Telephone: ( ) _____
Email: _____

Cardholder's Signature Date

_____ _____
Signature **Date**

As the credit card holder, I also authorize Piller Child Development, LLC to charge my credit card for future purchases verbally (or written) approved by me.
Your completion of this authorization form helps us to protect you, our valued customers, from credit card fraud.

- ☐ *Please automatically run this credit card for any outstanding balances after EOBs are reconciled*
- ☐ *Please call or email me before running this credit card for any outstanding balances after EOBs have been reconciled.*

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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 and patient rights.

☐ I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_____ _____
Parent or legal guardian signature Date

Due to the HIPPA laws now in effect we must have detailed information as to whom we may release medical information. Please read and check the appropriate areas as you see fit. This release is valid until you notify us in writing otherwise.

To whom may we release your medical, financial, and billing information?

Name	Relationship to Child
_____	_____
_____	_____
_____	_____

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.

_____ _____
Parent or legal guardian signature Date

_____
Printed Name

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

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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

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.