**PATIENT REGISTRATION – 2017 Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Childs Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address including City and Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother/Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father/Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother/Caregiver cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_Father/Caregiver cell phone: \_\_\_\_\_\_\_\_\_\_\_**

**Mother/Caregiver email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father/Caregiver email: \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name and Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL/INSURANCE INFORMATION**

**Pediatrician name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\***Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child have an IEP?  YES  NO**

**\*\*If marked yes a current copy of the IEP is required for service delivery. Please provide a copy to your evaluating therapist to coordinate services with school therapist. Which services and day of the week are services being provided at school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Private Insurance Company Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber ID#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Card Holder name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cardholder DOB: \_\_\_\_\_\_\_\_\_\_\_**

**Employer name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If not currently eligible, have you ever been eligible for Medicaid?  YES  NO
* Are you in the process of applying for Medicaid?  YES  NO
* Are you in the process of switching between Medicaid and Health choice?  YES  NO
* **Health choice ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date coverage began\_\_\_\_\_\_\_\_\_**
* **Medicaid ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date coverage began**\_\_\_\_\_\_\_\_\_\_

**MD Practice name listed on Front of Medicaid Card (if applicable) \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Protected Health Information (PHI)**

I consent for Shining Stars Therapy, PA to use the patient’s Protected Health Information (PHI) for the purpose of providing treatment, payment of services, and for Shining Stars Therapy, PA general healthcare operations purposes. PHI means for any information, including demographic information, created or received by Shining Stars Therapy, PA that relates to past, present or future health conditions: information that relates to the provision of health care; information that relates to past, present or future payment for the provision of health care services; and information that can be used and disclosed to identify the patient.

I have been notified how to access the Shining Stars Therapy Notice of Privacy Practices Policy (posted securely on the wall in the office lobby or at www.shiningstarstherapy.com) regarding my Health Information Rights under HIPAA, CFR §164.524 and I am aware that I am entitled to or may request my own copy of these policies.

**Caregiver name (printed)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to the child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Communication**

I consent for Shining Stars Therapy, PA to communicate with me regarding the care of my child which includes information regarding payment, scheduling and information regarding the progress of my child during the course of their care at Shining Stars Therapy, PA. I understand that voice messages may be left on the phone numbers I have provided and give permission for electronic mail (email) addresses I have provided between my Shining Stars Therapy provider and administrative staff. I understand that Shining Stars Therapy, PA is unable to encrypt email messages. The consent for these listed communications does not expire unless I provide a formal written request indicating specifically how and where I would like my Confidential Communications to Shining Stars Therapy, PA 304 Judd Place Drive Fuquay Varina, and NC 27526. Reference Right to receive confidential communications in notice of privacy practices 9/23/2013.

**Are there legal restraints prohibiting a caregiver or parent from having access to your child’s records?**  YES  NO \*\* If you checked Yes, we are require by law to request formal proof of full medical custody from you.

**Caregiver name (printed)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to the child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent or legal guardian) give my consent for Shining Stars Therapy, PA to provide the services listed below:

Evaluation

Treatment

Play to Learn Social skills group

Camp

Therapeutic Screening

Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I allow this treatment to be performed at the following treatment sites:

Office

Daycare

School

Home

In the absence of the parent/legal guardian, the following people may be present during therapy sessions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Parent Permission to leave the building

# \*\*\*\* applies only to services provided in the office

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for Shining Stars Therapy, PA personnel to provide first aid as needed to my child in case of an emergency. I also give Shining Stars Therapy, PA personnel permission to seek medical assistance in case of an emergency. If you have discussed leaving the office while your child is in therapy and you have discussed the above emergency plan with your therapist and they are in agreement, please provide the following information:

Current Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_ Circle: 1=mild 5=moderate 10=severe

Current medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will not hold Shining Stars Therapy liable for accidents that may happen in my absence.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Release Form**

Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shining Stars Therapy, PA is authorized to release or request any medical information, which is necessary in providing therapy services for my child from the following agencies:

\*Please indicate the **name** of professionals or agencies who have or work with your child\*

\*Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other therapists (OT/PT/SLP/DT):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitals/Clinics/Health Departments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School System: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CDSA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ophthalmologist/Optometrist:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge receipt of information and the Notice of Privacy Practices between Shining Stars Therapy, PA and the above named agencies/facilities and understand the conditions under which information will be used and disclosed. I understand the types of information that may be disclosed to the above named persons. I understand that I can add to or remove authorization of any person at any time in writing to Shining Stars Therapy, PA. 304 Judd Place Drive Fuquay Varina, NC 27526. This authorization will be in effect for one year from the date of the below signature.

**Parent Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attendance/Cancellation Policy**

In order to maintain quality treatment programs and maximize your child’s success, we need to have in place policies that will help to keep your child’s visits to be as consistent as possible.

If you need to cancel your visit, please inform your therapist as soon as possible, and more than 24 hours in advance. However, we understand that occasionally emergencies arise or children become suddenly ill, etc. Please notify us as soon as you are aware that your child will not be attending his/her therapy session for these reasons. This will allow us to plan our schedules accordingly. *We will make every effort to reschedule your visit in the same week if possible.*

If no prior cancellation is made (no call/no show), or cancellation occurs with less than 24 hour notice (with the exception of illness/emergencies) you may be charged a **$50.00** missed appointment fee. Shining Stars Therapy, PA also reserves the right to discharge or change your appointment to a cancellation list once your child misses 2 sessions without prior cancellation or if there is chronic scheduling difficulties.

An appointment that is started later **than 10 minutes** of scheduled appointment time will be cancelled and applied a cancellation fee of **$50.00** and considered a no show/no call with the exception of an emergency.

If your child is seen in the home, an adult must be on the premises at all times while our representative is providing therapy. If your child is seen in the clinic and you would like to step out to run an errand, you may do so once the Parent Permission to Leave the Building form has been completed. However, we do ask that you arrive back in the clinic at least 10 minutes prior to the time your child’s therapy session ends.

**Child’s Name (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child Illness Policy**

Please keep your child home from therapy or cancel home therapy under the following conditions:

* Fever/vomiting within the past 24 hours (this includes a low grade temperature)
* Highly contagious conditions, including the flu, stomach virus, diarrhea, conjunctivitis (pink eye), head lice, ring worm, etc.
* Severe respiratory problems (i.e. thick or excessive nasal discharge, severe coughing, etc.)

Please notify your therapist if your child has been exposed to/contracted any contagious illnesses, for example; strep throat, fifth’s disease, chicken pox, etc.

**Parent Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Billing Information/ Financial Policy**

**Authorization for Billing and Payment of Services:**

I authorize Shining Stars Therapy, PA to contact Medicaid and/or private insurance company to confirm benefits and release information necessary to process claims. I authorize payment directly to Shining Stars Therapy, PA for services rendered. I understand that I am responsible for any co-pay/co-insurance and/or deductible amounts associated with the patient’s benefits. **I understand that it is my responsibility to know my benefits and that verification of benefits by Shining Stars Therapy, PA is not a guarantee of payment.**

**Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person legally responsible for payment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to the child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Child’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize Shining Stars Therapy, PA to charge my credit card for my child’s Occupational Therapy, Physical Therapy, Developmental and/or Speech Therapy co-pays and/or services. I understand that Shining Stars Therapy, PA financial policy states that I am required to have a valid credit card authorization on file to process co-pays for services. Co-pays are due at time of service. *\*See financial policy referencing co-insurance, copays, and deductibles.*

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization:**  YES  NO (new card for 2017)

Card Type (check one):

□ Visa

□ MasterCard

□ Debit

Please check one:

* This is a Health Savings Account (HSA) card
* This is a credit/debit card

Name as it appears on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code of billing address\_\_\_\_\_

Verification Code (last three digits on signature panel):\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_