Pinnacle Pediatric Therapy of Lakewood Ranch

6215 Lorraine Rd | Lakewood Ranch | FL 34202 Phone: (941)758-4707 Fax: (941)755-3735

Tutoring & Social-Behavioral Services Intake Form

Child's Full Name _____DOB _____Age_____

Parent/Guardian Name_____

Address _____

Home Phone _____ Daytime Contact Number_____

Email Address _____

School/Daycare _____ Grade_____

Does your child receive additional support in the classroom setting (Please specify): _____

Pediatrician (PCP) _____ Phone: _____

Has your child received any diagnosis (Please specify): _____

Please list any medical conditions: _____

Does your child have allergies? Please list: _____

Please list any medications and dosage that your child is taking: _____

Does your child currently receive any of the following interventions? (check all that apply)

____Speech Therapy ____Occupational Therapy ____Physical Therapy
____ Applied Behavior Analysis ____ Mental Health Services Other: _____

I am interested in the following services for my child: (check all that apply)

_____ Tutoring Services _____ ABA-Behavioral Services _____ Social/Group Therapy

Main Concerns

_____

_____

_____

_____

_____ _____

Parent/Legal Guardian Signature Date

Office Use Only: Received by _____ Date _____ Patient Reservation Form Completed _____

Pinnacle Pediatric Therapy of Lakewood Ranch

SERVICE AGREEMENT/INSURANCE BILLING WAIVER

Child's Name _____

Consent to Treatment
I, the guardian of the above named child, voluntarily consent to treatment as recommended to be necessary or beneficial by his/her teacher or therapist. I acknowledge that no guarantees have been made as to the effects of such treatment on my child's individual condition.

Financial Agreement
I, the undersigned, guardian of the above named child, agree to be responsible for the payment of therapy services to Pinnacle Pediatric Therapy of Lakewood Ranch. I hereby agree to pay any and all charges for services received.

I understand that the following service(s) _____ is/are not covered by my insurance company or I elect not to have my insurance company billed for these services.

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Client's Rights and Responsibilities
I have read my Rights and Responsibilities and fully understand the information contained therein.

I certify that I have read and fully understand this form and am in agreement with the information explained in such form.

Invoices for rendered services will be sent to email address specified below:

_____
Email Address you wish to have Billing Invoice sent (Please Print)

_____ _____
Signature of Child's Parent or Guardian Date

_____ _____
Print Parent/Guardian name Relationship to Child

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ATTENDANCE AND SCHEDULING POLICY

1. I understand that a treatment session consists of 50 minutes of direct treatment. An additional 10 minutes is used for parent consultation, set-up, clean-up and transitions into and out of the treatment. _____(initials)

2. I understand that in order to receive the maximum benefit from treatment, it is important for treatment to occur at the treatment frequency determined between the therapist and family. I understand that notification of vacation or family obligation is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment. I understand that we may schedule make-up sessions for vacation times, if there are times available. _____(initials)

3. I understand that for sessions cancelled with less than 48 hours notice (unless the child becomes ill in the morning); a cancellation fee of $50.00 will be charged and is billed directly to me. I understand that if sessions are cancelled with more than 48 hours notice, I will not be charged a cancellation fee; however, this clinic encourages scheduling a make up for these and all other sessions in order to ensure optimal progress. _____(initials)

4. I understand that if we do not cancel and do not keep a scheduled appointment{NO SHOW}, we will be charged the full fee for the session. I also understand that three no shows will result in the termination of our treatment slot. _____(initials)

5. I understand that if my child was not well enough to attend school on the day of his/her appointment that I should not bring him/her to the scheduled therapy session that day. I also understand that if my child attends therapy, and then comes down with an infectious illness or condition such as strep throat, conjunctivitis, chicken pox, lice, etc. I should notify the clinic immediately so that other children in the area that day can be notified. _____(initials)

PAYMENT POLICY

1. I understand that the clinic cannot wait for payment and that my co-payments or private payment is due no later than 14 days from receipt of invoice. All checks are to be made payable to Pinnacle Pediatric Therapy Group. Payment may be mailed, delivered to the office, or paid through Quickbooks Online App _____(initials)

2. lf my account becomes overdue by 30 days, I understand that Pinnacle Pediatric Therapy Group will discontinue therapy until payment is made. _____(initials)

Pinnacle Pediatric Therapy of Lakewood Ranch

Pinnacle Pediatric Therapy Group Client Rights & Responsibilities

As a client of Pinnacle Pediatric Therapy Group, or as a family member or guardian of a client, we want you to know that we are committed to honoring your rights. By taking an active role in your therapy, you can help your providers to meet your needs.

You have the right to receive treatment without discrimination due to age, sex, race, or gender.

Rights

You have the right to:

• Receive information in a way that you understand.

• Receive information about your current treatment plan, outcomes, and recommendations.

• Be informed about proposed treatment options including the risks and benefits, other options, what could happen without treatment, and the outcomes of treatment.

• Be involved in all aspects of treatment and take part in decisions about treatment.

• Expect the provider to get your permission before taking photos, recording, or filming you/your child for the purpose of training, education, or media.

• Decide to take part in research or clinical trials related to treatment. Your participation is voluntary, and written permission must be obtained from you before you participate.

• A decision to not take part in research or clinical trials will not affect your right to receive treatment.

• Receive kind, respectful, safe, quality care delivered by skilled professionals.

• Know the names and credentials of providers who are treating you.

• Receive efficient and quality care with high professional standards that are continually maintained and reviewed.

• Expect all communications and records related to treatment to be treated as private and confidential.

• Receive written notice that explains how your information will be used and shared with other health care professionals involved in your treatment.

• Review and request copies of your treatment records unless restricted for legal reasons.

• Review, obtain, request, and receive a detailed explanation of your treatment charges and bills.

• Report any concerns or complaints regarding your treatment to the agency Director. This will not affect your future care.

• Expect a timely response to your complaint or grievance for the agency Director. This may be made in writing, by phone, or in person.

Responsibilities

We ask that you*:*

• Provide accurate and complete information about current health, education, and behavioral information.

• Provide a copy of any recent evaluations, diagnosis, medical records, or other health/ educational documentation that is important to treatment.
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• Recognize and respect the rights of other clients, families, and providers. Threats, violence, or harassment will not be tolerated.

• Comply with the agency's no smoking policy.

• Be actively involved in your child's treatment by participating in education, training, and observation of sessions as recommended by your provider.

• Ask questions if you are concerned about your treatment.

• Are responsible for paying your bills related to services rendered in a timely manner.

• Follow your treatment plan as developed by your provider(s) and participate in the development of your child's treatment plan.

• Notify the clinic office at 941-758-4707 if you must cancel a scheduled session or wish to change or discontinue services.

Thank you!
Pinnacle Pediatric Therapy Group