Kids in Stride
THERAPY DESIGNED FOR KIDS

Patient Express Registration

Today's Date :

Please fill out entire form Completely & Legibly

1. Personal Info

Last Name _____ First Name _____ Age _____ ___ Male ___ Female

Street Address _____ City _____ State _____ ZIP _____

(_____) Home Phone _____ (_____) Cell Phone _____ Email Address **(Important)**

Emergency Contact Person _____ (_____) Phone # _____ (If Minor) Parent/Guardian Name and Signature _____

Occupation _____ Employer Name _____ (_____) Phone # _____

- My condition is related to: ___ Work ___ Auto Accident (State _____) Other _____

Social Security # _____ Date of Birth ____/____/____ Single / Married / Divorced

Work Status: ___ Currently Employed ___ Retired ___ Disabled (___ Total or ____ Temporary) ___ Student (___ P/T ____ F/T)

2. Referral Info

(PLEASE PRINT CLEARLY)**

****How did you hear about us?****

If by a friend or family member, please give their phone number and address below so we may send a thank you note and gift.

Referring Physician Name _____ Your Primary Physician Name _____

Street Address of Referring Physician _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Do you have a follow-up appointment with this Physician? _____

If so, when? _____

3. Payment Info

(Check appropriate box or boxes)

PLEASE SELECT YOUR DESIRED PAYMENT METHOD.

Insurance: (Primary and Secondary)

- ❑ Medicare / Medicare HMO
- ❑ Medicaid
- ❑ PPO / Private / POS
- ❑ Worker's Compensation
- ❑ Auto Insurance
- ❑ VA Insurance
- ❑ Health Savings Account

Litigation / Lien: (**Note: Additional Paperwork Required)

- ❑ Auto Lien/Litigation
- ❑ Work Injury Lien/Litigation
- ❑ Other: (Specify)_____

Self Pay: (****Note**: Self pay rate is a community service **discounted rate** we offer as a courtesy to our patients/clientele. Paperwork and Administrative costs may incur additional fees. Please discuss any concerns with Billing Manager or Office Manager)

- ❑ Cash
- ❑ Check (s)
- ❑ Credit Card
- ❑ Care Credit
- ❑ Payment Plan (Additional Fees May Apply)

4. Additional Info:

I understand that I am directly and fully responsible to said provider for all therapy and/or medical benefits submitted by provider for services rendered to me or other person for which I accept financial responsibility and that this statement/document is made solely for said provider's additional protection. I understand that provider will not/does not receive immediate payment for my services, as such the balance of my account may accrue to a point at which the provider will need to ensure my credit worthiness to extend credit to me. I authorize Kids In Stride to verify my credit worthiness at any such time as may be deemed necessary. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court cost will be added to the total amount due.

Authorized Signature _____ Date: _____

Important Company Policies

We strive to provide you with the best personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully and indicate your acknowledgement by signing at the bottom. *Note: While these policies are not negotiable, we are VERY understanding of life situations and will try to work with you when or if those situations arise.

Late Policy "10-minutes" - Being late by more than 10 minutes may require you to reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We discourage appointment overlap due to tardiness because this undeservedly compromises the care of another patient.

Cancellation/No Shows - If you wish to change or cancel your appointment we require a minimum **24-hour advance notice.** Anything less may result in a **$25 fee** charged to your account. If you fail to show for an appointment without notice all future appointments may be removed and a **$25 fee** assessed to your account for that visit. You may reschedule appointments again on a "first come, first serve basis" when you have paid for the missed visit in full. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expense (for staff wages, rent, etc.). We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. We understand extenuating circumstances may sometime apply, if so, please let us know as soon as possible. YOUR COURTEOUS CONSIDERATION AND UNDERSTANDING ARE APPRECIATED.

Co-pays and Self-Payment will be due at time of each visit - If you happen to forget your wallet or checkbook we may still be able to see you however payment will be expected at the time of or before your next appointment. Additionally, if you fail to return for further visits you will still be responsible for any balance owed on your account. This allows you to keep your appointments however multiple offenses or extended delay in payment may result in a small surcharge.

Therapy/Service and Emotional Support (Comfort) Animals - We at Pro Motion Rehab respect the need for Service/Support Animals for those with a specific disability that would require such assistance. However, we are unable to accommodate Emotional Support Animals in the facility due to the difference in training, function and the potential difference in temperament. As allergies often cause certain patients to be unable to tolerate the dander on such animals and the potential for fleas to be left behind, we ask that you consider leaving your comfort animal in the care of someone that you trust. Americans With Disabilities cites that emotional support animals do not have the training to do specific tasks in assisting a person with disability or impairment, unlike service animals. Hence, the pets may not be allowed to accompany their owner in public places ie. restaurants, stores, hotels. Under the ADA and North Carolina law, owners of public accommodations are not required to allow emotional support animals, only service animals in their establishments.

Cell phones must be shut OFF or silent - We realize emergencies may arise and therefore allow you to carry your phone during your session, however please be courteous and set to vibrate / silent mode or turn off. Thank you.

Children or Minors requiring supervision are NOT allowed to be left unattended in the reception area - You may **not** bring children who require supervision with you and leave them **unattended** in the reception area. Likewise, if a child is a source of distraction from your care, we request that the child not attend your appointment. If your child does not require supervision and is capable of waiting for you quietly without disruption to our reception area then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Parental / Legal Guardian Supervision / Availability - Any minor under the age of 16 years will be required to have a parent or legal guardian present, onsite or readily available (on premises), while treatment is being rendered. Any minor under the age of 16 years left or dropped off by the parent or legal guardian will not receive treatment until the parent or legal guardian is readily available as described above. ***NOTE: A minor over the age of 16 years may be required to have a parent or legal guardian readily available if requested by therapist or office manager.**

Financial Hardship - If you are experiencing financial difficulties and are unable to afford co-pays associated with your services we have a "Financial Hardship Form" which may be filled out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portion of the bill. Ask the front desk person for assistance.

Important Notice from the Federal Government:
"It is unlawful to routinely avoid paying your co-pay, deductible or co-insurance payments… even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's—Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws, Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply.

I have read, understand, and agree to all the policies on this form.

Patient Signature: _____ **Date:** _____

Legal Guardian (Print Name): _____ **Signature:** _____

Assignment Of My Benefits

For Commercial Insurance, POS, Medicare, Medicaid, Med-Pay, PIP, Lien, Workers Compensation, Other Liability and Private Third Party Payers

1. Benefits Info

Please provide **all** insurance cards and information, as well as your driver's license or photo ID card. Benefits will be verified between our office and your insurance however, as stated by most insurance policies, *"a verification of benefits is not a guarantee of payment"*. **You are responsible for any co-insurance, co-payment, or *unmet* deductible amount at time of service/each visit.**

2. Policy Info

I hereby instruct and direct my insurance company, attorney, and/or person(s) responsible for settlement/payment services related to my claim/case to timely discuss and provide necessary information as well as to pay via check made payable and mailed to:

Kids In Stride 2810 W. US Hwy 64 Murphy, N.C. 28906
Office: 828-516-1700 Fax: 828-516-1701

If my/this current policy prohibits direct payment to above company, I hereby also instruct and direct you to **make the check jointly payable to myself AND Kids In Stride and mail it to the above address for the allowable professional or medical expense benefits,** and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment **will not** exceed my indebtedness to the above-mentioned assignee. I agree to pay, in a prompt manner, any balance of said professional service charges not paid by my insurance or designated responsible party. (co-pays, deductible, or denial). (Sign and date this document at the bottom)

- A photocopy or fax copy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney directly involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize Kids In Stride, Inc. to deposit insurance checks made in my name for their services.
- I authorize Kids In Stride, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- **I understand that I am ultimately financially responsible for the services I receive whether or not paid by my insurance, settlement, or any other entity that I initially provided for said payment to Kids In Stride.**
- **I authorize the release of any information regarding my clase/claim to/from ProMotion Rehab from/to any insurance provider, attorney, adjuster or any other related party.**

***Note: Providers may not bill any patient more than has been allowed by the insurance company with which they contract.**

NOTE: We accept cases of personal injury where fault is or is NOT determined. We reserve the right to **request payment be made at the time of service** even in cases where an attorney is involved. In certain cases we may defer payment until the cases settles, however, a **lien agreement** will be required to secure payment. We **do not charge any fees** for this service even though we may not receive payment for services provided for 12-24 months. Please be informed that **we do not accept "discounted settlements". We will not change the payor to your private insurance after you have been discharged unless your case has settled and no money had been awarded.** Please understand **all** amounts are due and payable by patient or their guardian/parent (for minor patients). **The patient or guardian/parent is responsible for all charges** regardless of the outcome of the case.

If it becomes necessary for Kids In Stride to retain a collection agency or legal counsel to assist with collection of any unpaid patient responsible balance, by your signature below you agree to assume responsibility for all related fees.

Please note that any documentation requests and/or deposition appearance requests by an attorney other than your own or yourself may incur additional fees. We do not accept all cases and reserve the right to refuse service to anyone.

Dated this _____ day of _____ 20____.

Signature of Policyholder	Witness	Signature of Claimant, if other than Policyholder

V1.2018.1

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NOTICE TO MEDICAID PATIENTS

As a requirement of Medicaid we must obtain preauthorization for all Medicaid visits prior to initiating any treatment or procedures other than the initial evaluation. Once authorization has been secured and verified by our office from Medicaid we are required to maintain a frequency of visits for the authorized treatments as initially requested from Medicaid. Generally speaking, this is usually 1-2 visits per week. If these visits are not maintained as authorized or if you do not attend therapy according the frequency of authorization, Medicaid will deny any further visits and we will not be able to re-obtain authorization for therapy services for the current issue. While we advocate on your behalf to provide the necessary treatment we also are contractually obligated to abide by the regulations as set by Medicaid (since they are paying for your therapy). As such, if you do not maintain the 1-2 visits per week as recommended by the Therapist and/or Doctor we will have to discharge your current case and no further visits will be allowed for the current problem for which you have been or are being seen.

Please help us to help you by keeping all visits as recommended and/or ordered by your Therapist and/or Doctor.

Thank you for your anticipated understanding of this policy.

Sincerely,

Elizabeth Ference
Kids In Stride

I acknowledge that I have read the above notice and agree to maintain the frequency of visits as required by the Therapist and/or Doctor.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Guardian Date

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NO SHOW/CANCELLATION POLICY

If you cancel an appointment and are able to re-schedule within the week to reach your prescribed appointment frequency and/or you give 24-hour notice (voice mail is acceptable), this policy will not apply.
-2 No Shows *within a month* will result in a letter being mailed informing the caregiver(s) of removal of the patient from all scheduled future appointments. The caregiver(s) will have opportunity for contacting our office and scheduling appointments on a weekly basis vs. a monthly basis. We will call to confirm appointments the day before to ensure no appointments are forgotten, so please make sure we have a good contact number on file.
-2 Untimely Cancellations *within a month* (that were unable to be re-scheduled and did not provide a 24-hour notice to our office) will result in letter notifying caregiver(s) of removal from future appointments and only the ability to schedule on a weekly basis (not on a monthly basis). *The month begins on the 1st day of the month and ends on the last day of the month. The cancellation policy begins again the next month to ensure fairness for unexpected illnesses/circumstances.*

As this has become a growing issue, **we will be enforcing this policy**. Please note, we maintain a waiting list of patients who are trying to get appointment times that work with their schedule and we try to be as accommodating as possible for the benefit our patients. We gladly reserve your time with a **one on one Therapist** to ensure **individualized treatments**. This Therapist is available to your child for their **scheduled treatment times**. When you do not show up for a **scheduled appointment** or do not give us **24-hour notice**, it creates an **unused appointment slot** that could have been used for another patient. Also, as we are unable to fill that time slot for the therapist that had reserved that hour, Kids In Stride has to absorb the costs of paying the therapist for that hour without compensation to Kids In Stride. We understand that there may be extenuating circumstances that occur without your ability to contact our office within 24 hours, which is why we are allowing **2 untimely cancellations or 2 no shows** within a month (see policy above). We initially allow the caregiver(s) to schedule children for up to 3 months at a time as a courtesy and to accommodate the need for specific times and consistency. This is an efficient privilege reserved for those that attend regularly and follow policy, however if you are not regularly attending these appointments (which is taking time away from other patients and costing Kids In Stride uncompensated fees) it will be revoked.

If you have any questions or concerns in regard to this process, we will be happy to discuss.

Signature: _____ Date: _____

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Consent, Authorization and Release of Photos, Video, and Statements

I hereby grant to Kids in Stride permission to use photographs, videos, and statements of me (or my minor child). I acknowledge, grant, and assign to Kids in Stride ownership and exclusive copyrights to reproduce, use, exhibit, display, distribute and create derivative works indefinitely for the purpose of marketing.

I authorize Kids in Stride to use and disclose photos, videos, and statements made by our patients, potential patients, customers, employees, or the general public in any media now known or later developed, including, but not limited to print media, video presentations, news releases, and/or social media for purposes of marketing for Kids in Stride.

Authorization to Disclose

I understand that after any photo, video or statement is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign this authorization will not affect my ability to obtain treatment or my eligibility for benefits, unless allowed by law. This authorization will be valid for twenty years.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Kids in Stride. Notwithstanding the foregoing, I understand that the revocation will not apply to information that has already been disclosed and that it will not revoke my grant and assignment of legal title and exclusive copyrights of the photos, videos, and statements to Kids in Stride.

Waiver and Release

I waive any right to royalties or other compensation arising from or related to the use of the above-mentioned photos, videos, and statements at any time. I hereby agree to release, defend, and hold harmless Kids in Stride for any damages, attorney fees, costs, fines, penalties, claims, or liability arising from or related to the use of the same. I hereby represent and warrant that I am competent to and have the legal authority to execute this Consent.

I confirm that I have read and understand the above, had an opportunity to ask questions, and agree to all the foregoing.

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

Patient Name_____

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We enjoy and welcome siblings, relatives, and friends present for your child's therapy sessions!

If siblings, friends, or relatives of the child are participating in patient treatment sessions, please be aware; they are participating/playing at their own risk and are to be supervised by a parent, guardian, or caregiver at all times.

By signing this form, you are consenting to the above guidelines.

Parent/Guardian (print name): _____

Parent/Guardian (signature): _____

Date:_____

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PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Kids In Stride HIPPA Notice of Privacy Practices for Personal Health Information.

Release of Information [ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to _____

[ ] Information is not to be released to anyone. This Release of Information will remain in effect until terminated by me in writing.

_____ _____
Patient Name Date

_____ _____
Signature of patient or personal representative If personal representative, personal representative's authority to act

Witness:_____ Date: _____

For Kids In Stride use only:

Patient [□ has □ has not] signed an acknowledgement of the CURRENT Notice of Privacy Practices either attached here or as documented in the patients chart.
You must complete this section if this form is not signed and dated by the patient or patient's representative and no signed acknowledgement of receipt of the current notice of privacy practices is on file in the patients chart.

Patient Name: _____ Date of Birth: _____
Phone number: _____
Address: _____
The date that you requested the signature and date:_____
The reason that the signature and date were not obtained: _____
_____
_____