Today's Date: _____

WELCOME TO LEAPS & BOUNDS, PT!

Please fill in all paperwork completely and to the best of your knowledge.

Personal Information:

Patient's Name: _____ **DOB:** _____

Parent/Guardian's Name: _____

Patient's Home Address: _____

_____

Contact Phone Numbers: (home) _(_____)_____

(cell 1) __(_____)_____ **(cell 2)** __(_____)_____

Referral Information:

Please tell us who referred you/how you heard about Leaps and Bounds?

_____

_____

_____

Primary/Referring Physician's Name: _____

Phone Number: __(____)_____

Name and Phone Number of any additional Physicians the patient may visit:

_____ ___(____)_____

_____ ___(____)_____

_____ ___(____)_____

IMPORTANT COMPANY POLICIES

Please initial each box.

☐ **Late policy** – Being more than **15 MINUTES LATE** for an appointment will require rescheduling, or waiting until the next available opening. There are no guarantees the patient will be seen that day, since cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of both patients.

☐ **No shoes in therapy area** – We have worked to create a sterile and sanitary environment for your children to "play" in. Therefore, it is office policy that no shoes are to be worn in the therapy area. We also do not permit bare feet. If you don't have socks, we can provide shoe covers for your convenience. There is a shoe rack located just past the door where shoes can be stored during your child's session.

☐ **Cell phone must be silent** – We realize that an emergency may arise and you need access to your cell phone. However, please be courteous and set it to silent mode or turn it off during the session. If you must make a call, please step into the hallway.

☐ **Children require supervision at all times** – All children require adult supervision at all times, either with a parent or therapist. It is **NOT** appropriate to leave children alone in the waiting area and it is **NOT SAFE** to allow them to roam the building unsupervised. We encourage parents to be in therapy sessions whenever possible. Siblings may join the patients in the therapy area if they can refrain from disrupting treatment, of both their own sibling and any other children who may be receiving therapy at that time. If patients do not do well with parents in the room, or if siblings are distracting, please stay in the waiting area.

I have read and agree to all the above policies. I recognize that policies are subject to change at the discretion of Leaps and Bounds, PT.

Parent/Guardian's signature: _____ Date: _____

Leaps and Bounds, PT

ASSIGNMENT OF BENEFITS

Primary Insurance:

Insurance Name: _____ Name of Policyholder: _____

Employer: _____ Policyholder DOB: _____

Relationship to Patient: _____

Secondary Insurance:

Insurance Name: _____ Name of Policyholder: _____

Employer: _____ Policyholder DOB: _____

Relationship to Patient: _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Leaps and Bounds, PT
1931 Richmond Avenue, Suite 203
Staten Island, NY 10314
718-477-1911

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me, and mail it to the above address for the professional and medical expense benefits allowable, 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, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Please check each box and sign the bottom.

- ☐ A photocopy 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 involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize Leaps and Bounds, PT to use this signature on all insurance submissions.
- ☐ I authorize Leaps and Bounds, PT to deposit checks made in my name.
- ☐ I authorize Leaps and Bounds, PT to complain to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges that are paid out to me by insurance.

Policyholder's Signature: _____ Date: _____

Office Staff Initials: _____

INSURANCE INFORMATION

We are currently **Out of Network** with **all** insurance companies.

What does this mean for me?

Insurance company checks and EOBs (explanations of benefits) may be mailed straight to your home. We will receive the information that you have been paid. If you don't receive anything, it is possible that checks have been mailed directly to our office.

What am I financially responsible for?

As a courtesy, Leaps and Bounds, PT will not collect in full the visit amount, as the insurance company suggests we do. Instead, by signing this form, you agree to bring in all complete EOBs and checks mailed to you. We require the policyholder to endorse the check, but you **do not** have to cash it. Just bring it in at your child's next visit, or mail it to us.

Why do I have different charges for each therapy visit?

Therapy is billed differently than most doctor visits. Instead of billing a single code for the visit, we must bill for each procedure performed and by the amount of time that the procedure was performed. This means that, on your explanation of benefits, it is normal to see four or five billed codes. As for the different charges, it is our hope that your child will be progressing with each visit to our office. This means that, each time your child receives therapy, we will be adjusting their treatment to follow their development.

Please check each box and sign the bottom.

☐ I understand that I am responsible for bringing in all checks sent to me by my insurance company for services rendered.

☐ I understand that I will be financially responsible if I deposit or cash checks meant for services rendered to Leaps and Bounds, PT.

☐ If I fail to bring in any checks owed to Leaps and Bounds, PT, I agree to be charged the amount owed on my credit card on file.

☐ I recognize that policies are subject to change at the discretion of Leaps and Bounds, PT.

I have read and agree to all the above policies.

Parent/Guardian's signature: _____ Date: _____

Leaps and Bounds, PT

STATEMENT OF PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

- We may disclose your child's healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.
- We may disclose your child's healthcare information to your insurance provider for the purpose of payment or healthcare operations.
- We may disclose your child's healthcare information to notify or assist in notifying a family member or another person responsible for your child's care about their medical condition or in the event of an emergency or of your child's death.
- As required by law, we may disclose your child's health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products and reactions to medications, and reporting disease or infection exposure.
- We may disclose your child's health information in the course of any administrative or judicial proceeding.
- We may disclose your child's health information to a law enforcement official for purposes such as identifying and locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose your child's health information to coroners or medical examiners.
- We may disclose your child's health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose your child's health information to researchers that have been approved by an Institutional Review Board.
- It may be necessary to disclose your child's health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- We may disclose your child's health information for military, national security, prisoner and government benefits purposes.
- We may leave a message on an answering machine or with a person answering your phone for the purpose of scheduling appointments. No personal health information will be left during this message.
- You have the right to request restrictions on certain uses and disclosure of your child's health information. Please be advised, however, that we are not required to agree to the restriction you have requested.
- You have the right to have your child's health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your child's health information.

Patient's Name: _____

Continued on next page

- You have a right to request that we amend your child's protected health information. However, we are not required to agree to amend it.
- You have a right to receive an accounting of disclosures of your child's protected health information made by us.
- You have a right to a paper copy of this Notice at any time upon request.

We reserve the right to amend this Notice at any time in the future. Until such amendment is made, we are required by law to comply with the Notice. If you have any questions about this Notice, or want more information about your child's privacy rights, please contact us at (718) 477-1911.

If you are not satisfied with the manner in which this office handles your child's privacy, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue SW
Room 509F HHH Building
Washington, DC 20201

I have read this Notice and understand my child's rights as contained within.

By way of my signature, I provide Leaps and Bounds, PT with my authorization and consent to use and disclose my child's protected healthcare information for the purposes of treatment, payment and healthcare operations as described in this Notice.

Patient's Name: _____

Parent/Guardian's Signature: _____ Date: _____

Office Staff Signature: _____ Date: _____

IN MOTION PT, PLLC D/B/A LEAPS AND BOUNDS, PT
PARENTAL RELEASE AND CONSENT

I, the undersigned, being the parent or legal guardian of the unemancipated minor set below (the "Minor"), and acting for and on the Minor's behalf, do hereby release, consent, and grant the following rights and permissions (this "Release and Consent") to **In Motion PT, PLLC d/b/a Leaps and Bounds, PT** ("Leaps and Bounds"), together with its officers, directors, employees, legal representatives, agents, affiliates, and assigns, those for whom Leaps and Bounds is acting, and those acting with their authority and permission (collectively, the "Authorized Persons").

The Authorized Persons may record the Minor's image, voice, or likeness in photographs, videotapes, digital recordings and/or other records or materials (the "Recorded Likeness") and may publish, license, and use such Recorded Likeness, with or without the inclusion of Minor's name, in connection with advertising and promoting the business of Leaps and Bounds ("Promotional Materials"). The use of the Recorded Likeness in the Promotional Materials is without restriction of any media posts (i.e., Twitter, Facebook, Instagram and similar services), print advertising and other promotional materials in any and all manner of media worldwide. I agree that the Recorded Likeness may be altered or edited and that neither I, nor the Minor, shall have any ownership or any other interest in the Recorded Likeness, nor shall either of us be entitled to receive any royalty or other compensation for the use of the Recorded Likeness, or have any right to inspect or approve any use of the Recorded Likeness, including any text or other materials which may accompany the Recorded Likeness.

Each of the Authorized Persons is hereby released, discharged, and shall be held harmless from and against any liability in connection with the making and use of the Recorded Likeness as permitted herein, including, but not limited to, any claims or liability based upon or relating to any right to privacy, publicity, and/or confidentiality, and any claims or defamation and/or copyright infringement. Without limiting the breadth of the foregoing, this Release and Consent shall be interpreted to satisfy the requirements of section 50 of the New York City Rights Law.

I hereby represent and warrant that I am a parent or legally appointed guardian of the Minor and that I have the right to enter into this Release and Consent for and on behalf of myself and the Minor.

Parent/Guardian's Name (print): _____

Address: _____

Minor's Name: _____

Minor's Date of Birth: _____

Parent/Guardian's Signature: _____ Date: _____