In Home Occupational Therapy
P: 513-309-3905 F:650-560-2530
Email: info@kiddotherapy.com

CONTACT INFORMATION

Patient's
Name_____DOB_____
_____

Parent/Guardian's
Name_____DOB_____
_____

Other Parent/Guardian's Name (if applicable)_____
DOB_____

Address:_____

Phone:_____

CONSENT TO RECEIVE TREATMENT

I hereby give my agreement and consent to kiddOTherapy to furnish appropriate rehabilitative care and treatment according to the recommended plan of care as discussed with my therapist.

ATTENDANCE/CANCELLATION/NO-SHOW POLICY

- If you need to cancel please call or text, with as much notice as possible, prior to your appointment time.
- Understand that you may be discharged from occupational therapy if you cancel or are not home for 3 scheduled appointments.
- If you are not at your home within 15 minutes of your appointment time, and have not called to notify the therapist, this will be considered a no show for a scheduled appointment.

PRIVACY PRACTICES

_____
(Please Initial)

I acknowledge that kiddOTherapy's Privacy Policy regarding protected health information (PHI) was discussed with me.

○ Yes, I received a copy of the privacy policy.

○ No, I declined to receive a copy of the privacy policy.

_____
(Please initial)

I authorize kiddOTherapy to release records and medical information to my insurance company and primary care physician.

_____
(Please initial)

I agree that telephone messages regarding my appointments and protected health information may be left for me on
voicemail, text message, and email addresses at the following numbers and may be updated by me at any time:

Phone: ( ) - E-mail:
_____

Phone: ( ) -

Phone: ( ) - E-mail:
_____

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I agree that my protected health information (PHI) may be shared with the following individuals and/or agencies:

1._____ 2._____
3._____

Primary Care Physician (PCP):_____

INSURANCE INFORMATION AND RESPONSIBILITIES

Primary Insurance: _____
ID #: _____

Policy Holders Name:_____SPOUSE/ PARENT/ GUARDIAN

Date of Birth: _____ SSN: _____

Address if different from Patient:_____Phone Number: _____

Employer:_____Phone Number:_____

I have secondary insurance: YES / NO (Please circle)

Secondary Insurance: _____ID #: _____

Policy Holders Name:_____ SPOUSE/ PARENT/ GUARDIAN

Date of Birth: _____ SSN: _____

Address if different from Patient:_____Phone Number: _____

Employer:_____Phone Number:_____

I hereby declare that the above insurance information is correct. Your health insurance is based upon a contract between the insured party's employer and the insurance company, or in some cases, between you and the insurance company. It is your responsibility to notify our office of any changes or termination of your plan. Failure to do so will result in direct billing to the patient for the full amount of service rendered. I have read and understand the billing responsibility between myself and kiddOTherapy._____(Please initial)

Payment is due at time of service.

( ) I have insurance that covers 100% of coverage for occupational therapy but I am responsible if insurance is terminated.

( ) I am a cash pay patient and I agree to pay $175 for initial evaluation and $100 for each follow up visit.

( ) I understand that I am responsible for my copay of $ _____, which I will pay at the time of service.

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( ) I understand that I am responsible for _____% of my total/contracted rate due at the time of service.

I _____, understand if I do not pay my account with kiddOTherapy in full, my account may be assigned to a collection agency for collection. I understand if my account is assigned to a collection agency, the collection agency will charge a commission or fee that may be as much as 50% of the amount I owe to kiddOTherapy. In addition to this fee/commission, a monthly service charge of $10.00 per month will be charged for overdue accounts 45 days past initial billing date. I understand and agree that in the event legal action is commenced to force my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

By signing below, you acknowledge that you have read our policies and agree to all the above terms and conditions, and understand that treatment may be terminated if you fail to comply with kiddOTherapy's policies.

Signed: _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)