



## INTAKE INFORMATION

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Family Email:** \_\_\_\_\_

**Mother:** \_\_\_\_\_ **Wk Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Father:** \_\_\_\_\_ **Wk Phone:** \_\_\_\_\_

**Insurance Co.:** \_\_\_\_\_ **Payer:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Insured Person:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**ID and Group #:** \_\_\_\_\_ **Type:** \_\_\_\_\_

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Physician/Service Providers (please give names of all that apply: pediatrician, neurologist, orthopedist, ENT, any other providers)

Doctor: \_\_\_\_\_  
Type: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_  
Type: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_  
Type: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**CFC Ongoing Coordinator**  
Name: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

School: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Services Received: \_\_\_\_\_

.....  
I authorize Sovereign Pediatric Therapy to forward copies of my child's Therapy Progress Reports to the above doctors/CFC directors.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

# Parent Authorization Form

## 1. Emergency Release

I, \_\_\_\_\_, give my permission for Sovereign Pediatric Therapy to obtain emergency medical for my care in case of an emergency while my child is receiving treatment at Sovereign Pediatric Therapy. I hereby release and hold harmless Sovereign Pediatric Therapy. from any responsibility for any emergency care sought per my permission via this Emergency Release.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## 2. Picture Release Form

I, \_\_\_\_\_, give my permission to Sovereign Pediatric Therapy staff to photograph and/or videotape my child, \_\_\_\_\_ DOB\_\_\_\_\_. These photos and videotapes may be used for establishing home programs, documenting therapy progress, educational presentations, and /or Sovereign Pediatric Therapy public relations.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## 3. Name Release Form

I, \_\_\_\_\_, give my permission to Sovereign Pediatric Therapy. staff to use my child's name, \_\_\_\_\_ DOB \_\_\_\_\_. My child's name may be used in the quarterly newspaper to announce their birthdays.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### **Therapy Attendance**

The goal of Sovereign Pediatric Therapy is to provide your child with the best possible therapy services and the best possible therapy outcomes. Frequent cancellations interfere with the effectiveness of therapy by delaying the accomplishment of therapy goals and extending the duration of therapy required. For these reasons, we ask that you **make a commitment to regular therapy attendance** by your child and avoid scheduling doctor and other types of appointments/activities at times that your child would normally be attending therapy.

### **Cancellations**

Sovereign Pediatric Therapy reserves your scheduled therapy times exclusively for your child or child's group. Last minute cancellations preclude the use of those times for other children who may be waiting for evaluation and therapy times.

**Sovereign Pediatric Therapy requires a minimum 24-hour notice for all cancellations.** For planned vacations or other unavoidable activities which require a cancellation of therapy, **we request that you notify the front office as soon as you are aware of the need to cancel therapy**, but with a 24 hour minimum notice.

### **Sickness/Hospitalizations**

Children should not be brought to therapy when they are sick. Children must be free from a fever, diarrhea and vomiting for at least 24 hours before coming to therapy. If your child has any of these conditions the day before a scheduled therapy appointment, you should cancel your child's appointment for the next day with enough time to allow a 24-hour notice of cancellation. If your child has been hospitalized 24 hours or longer for any reason (illness or surgery), a new prescription from the doctor is needed to reinitiate therapy. The easiest way to obtain the prescription is to request it from your physician upon discharge from the hospital. Normally, a child is not taken off of the schedule when hospitalized unless specifically requested by the parent or if the hospitalization will last more than two weeks. On the first visit to the Sovereign Pediatric Therapy after the hospitalization, please bring the prescription explaining what your child was hospitalized for

### **Frequent Cancellations**

A child who frequently misses their regularly scheduled appointments may be asked to attend on an on call basis, move to another more convenient time or discontinue services, at the discretion of the Sovereign Pediatric Therapy.

### **No shows**

Any missed appointment without a cancellation call in advance will be charged a \$50.00 No Show charge which must be paid at or before the next scheduled visit. Services can only be resumed after all No Show charges have been paid in full.

**Sovereign Pediatric Therapy does not follow the school calendar and is open on many school holidays.** If you are unsure whether your child will have therapy on a school holiday, please call the day before to check in order to avoid a No Show charge.

**I have read, understand, and agree to follow the above policies related to therapy attendance.**

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Parent's/Guardian's Signature

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Date

## Co-Pay Policy

Many patients have co-pays as part of their medical insurance coverage. It is the policy of Sovereign Pediatric Therapy that co-pays and co-insurance are to be paid at the time of the visit, before the session begins.

## Statement Balance

You will receive a monthly statement of charges and payments posted to your account. Any past balance will be posted at the top of the itemized section of the statement. At the bottom of your statement, you will see an Amount Due section which indicates the balance for which you are responsible. It includes any past balance, any unpaid co-pays, any deductibles and any charges for which your insurance has denied payment.

The Amount Due must be paid before the last day of the month in which you receive the statement.

Your payment may be mailed in or brought with you to a therapy session and left with the receptionist at the front desk.

Any patient balances not paid before the last day of the month will be subject to a \$10.00 late fee each month until the balance is paid. Any patient balances that are past 90 days will result in the child being taken off of the schedule until such balance is paid in full. All patient balances that remain unpaid over 120 days are subject to collection action.

## Financial Agreement

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**Child's Name**

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**Date**

I recognize and accept full personal financial responsibility for all professional services rendered. Any verification of insurance benefits by Sovereign Pediatric Therapy is for the convenience of the undersigned and does not hold Sovereign Pediatric Therapy responsible for the collection of any insurance payments of Sovereign Pediatric Therapy. Payment is due at the time of service unless other arrangements are made per the agreement of Sovereign Pediatric Therapy. If the center is forced to pursue legal means for collection for money owed for services rendered, the person/s signing below will also be responsible for any costs incurred by Sovereign Pediatric Therapy in pursuit of collection, including court costs, costs of service, any and all attorney's fees, and any other expenses incurred for collection of said moneys owed.

I assign benefits and authorize insurance payment directly to Sovereign Pediatric Therapy, I authorize Sovereign Pediatric Therapy., to release any information required to process any claims.

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**Parent's/Guardian's Signature**

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**Date**

## **Patient Information Consent Form**

I have read and fully understand Sovereign Rehabilitation's Notice of Patient Information Practices. I understand that Sovereign Rehabilitation may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Sovereign Rehabilitation will consider request for restriction on a case-by-case basis, but does not have to agree with the request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Sovereign Rehabilitation's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

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**Parent's/Guardian's Signature**

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**Date**