****Pediatric Partners dba

**Aspire Therapy**

Pediatric Specialists

**Notice of Privacy Practices**

**You will be asked to sign that you received this information and understand it.**

We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please use the contact information on the signature page with your rights.

**Your treatment sessions:**

**It is our utmost intentions that your confidentiality be honored at all times. Aspire Therapy will discuss your child’s therapy session upon pick up. This may occur in the waiting room, treatment room, outside or on the way to your vehicle to leave. We will not use any of your identifying information when discussing how the session went or what activities we did during therapy. If you request a private confidential communication about your child’s session, please notify your therapist immediately.**

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about your for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for the services we provide for you.

**Healthcare Operations:** We may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. You revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:**  We must disclose your health information to you to notify, as described in the Patient Rights sections of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree we may do so.

**Persons Involved in Care:** We may use of disclose health information to notify, assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of healthcare.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required by law to do so.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your safety or the health and safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official’s health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correction institution or law enforcement officials having lawful custody of protected health information of inmate or patients under certain circumstances.

**Appointment Reminders:** We may use or disclose health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).



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**THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED**

**HEALTH INFORMATION ABOUT YOU MAY**

**BE USED, DISCLOSED AND HOW YOU CAN**

**GET ACCESS TO HIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY**

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information will be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of the notice.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private. Your therapist can discuss your child’s session with you upon pick up in the therapist room or waiting room unless you request a private conference.

If you have any questions about this notice, the name and phone number of our contact person is listed on this page.

Anna Toro

Director of Operations

623-972-4033

I herby acknowledge that I have received a copy of the NPP. I understand that if I have questions or complaints regarding my privacy that I may contact the person listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

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**Aspire Therapy**

Pediatric Specialists

**DIET RESTRICTIONS/ALLERGIES**

Child’s Name­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To ensure the safety of your child during his/her therapy sessions, please indicate below any diet or food restrictions that we should take into consideration while providing treatment.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for my child to participate in feeding therapy and/or sensory integration activities involving food and have reviewed my child’s diet restrictions with his/her Therapist(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

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**Aspire Therapy**

Pediatric Specialists

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent for Physical, Occupational and Speech Therapy**

I understand that therapy delivered through the utilization of customary and usual techniques has been used to treat carious neurological, orthopedic and medical problems. If therapy is ordered for the client by attending physician or suggested by the therapist and approved by the physician, I desire this service to be preformed and have the authority to request such service. I am free to discontinue treatment at any time.

**Consent for Release of Information**

I hereby give permission for designated health care providers to transmit to Aspire Therapy any, medical, therapy or laboratory reports that may be of assistance in assuring continuation of above client’s health plan. I hereby give permission to Aspire Therapy to release records (including, but not limited to evaluations, treatment and progress notes) to client’s physician, insurance company, and/ or the following (please specify):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Render Emergency Services to a Minor Child**

I understand Aspire Therapy or its representative will take whatever measures are deemed necessary in the event a medical or other emergency occurs in my absence. I also understand Aspire Therapy or its representative will authorize other medical or paramedical personnel to take such actions as may be necessary to perform the standard of care given in similar emergency situations.

**Assignment of Benefits**

FOR AND IN CONSIDERATION of the provisions of therapy services to the above patient, I hereby assign, transfer and set over to Aspire Therapy all my rights, title and interest in insurance benefits for the services rendered. I hereby authorize payment made directly to Aspire Therapy. I understand that I am financially responsible to Aspire Therapy for any charges incurred during the course of treatment and verification of benefits does not guarantee payment by the insurance company.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

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Pediatric Specialists

Dear Parent,

Thank you for choosing Aspire Therapy. Here is a Parent Pack that we at Aspire Therapy give to all new parents and patients. The folder is yours to keep. You can use it to save the evaluation reports and progress reports.

On the right side of the folder, you will find some new forms to fill out and bring with you on you visit to the clinic;

1. The Child History Form has questions that will help the Therapists get to know your child.
2. There is a form that gives us permission to perform therapy on your child, gives us permission to release records to the physician and insurance company, gives us permission to give care to your child should you wish to leave the facility during therapy sessions and permission to bill and receive payment from your insurance too.
3. There is a form which describes our privacy policies as set for by HIPAA.
4. The Telehealth Informed consent form gives the therapist the opportunity to film sessions to supervisor for approval and any new instruction. This HIPAA compliant and feel free to ask any questions.
5. Financial forms and office policies

On the left side of the folder, you will find some material that we thought would be informative to you. You may keep these.

We are looking forward to providing services for your child. If you have any questions, please feel free to call us. We want this to be a great experience for you and your child.

Respectfully,

Anna Toro

Director of Operations

Annatoro@aspiretherapy.com

623-972-4033

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**Aspire Therapy**

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Client History/Intake Form

Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ M F

**Contact Information**

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_ Birth Step Adoptive Foster

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_ Birth Step Adoptive Foster

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Family Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

**Primary Insurance Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Plan Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is the policy holder for this plan?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If Applicable:**

**DDD Support Coordinator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AHCCCS Insurance Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician**

Currently, who is your child’s primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Information**

Who referred your child to therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Diagnosis**

Does your child have a diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who made the diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_At what age? \_\_\_\_\_\_\_\_\_\_\_

Has your child received therapy before? NO Speech Occupational Physical Music

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy & Birth History**

Length of Pregnancy: \_\_\_\_\_\_\_\_\_\_ Birth Weight: \_\_\_\_\_ lbs, \_\_\_\_\_ oz.

Type of Delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were there complications with delivery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Jaundice\_\_\_\_ Breathing \_\_\_\_ Heart Problems\_\_\_\_ Seizures\_\_\_\_ Anoxia\_\_\_\_ Poor Suck \_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infant’s stay at hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NICU length of stay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty with eating/feeding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty with sleeping: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Health & Medical History**

Has your child experienced the following conditions?

NO YES AGE DESCRIBE

Pneumonia \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chicken Pox \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear Infections \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head Injury \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anoxia (lack of oxygen) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sustained High Fever \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Illness \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reflux \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeding Difficulties \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any medical procedures, surgeries or hospitalizations?

NO YES AGE DATE DESCRIBE

Tracheotomy \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

G-Tube \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shunt \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear Tubes \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tonsillectomy \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adenoids Removed \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Surgery \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history of any genetic, neurological, psychological or educational disorders?

Disorder Family Member Age Diagnosed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your child’s general health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Test/Screen NO\_\_\_\_ YES\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Test/Screen NO\_\_\_\_ YES\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on any medications? NO\_\_\_\_\_ YES\_\_\_\_\_

Name of Medication Purpose Dosage Start/End Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of other Physicians involved with your child’s care:

Physician Specialty Location

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Developmental Milestones**

Gross Motor

At what age did your child:

Lift head \_\_\_\_\_\_\_\_ Roll over \_\_\_\_\_\_\_ Sit w/o support \_\_\_\_\_\_\_ Crawl \_\_\_\_\_\_\_\_\_\_\_\_ Stand Alone\_\_\_\_\_\_\_ Walk\_\_\_\_\_\_\_\_ Dress/Undress \_\_\_\_\_\_\_\_ Button/Zip\_\_\_\_\_\_\_\_\_ Start solid foods \_\_\_\_\_\_\_\_ Held Cup \_\_\_\_\_\_\_\_\_ Used Spoon \_\_\_\_\_\_

Hand preference \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gain Bowel/Bladder Control \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dry during day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dry during night \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any bladder/bowel difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What positions does your child spend most of his/her time in at home? (held, stomach/back, sitting, etc…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your child’s independence with self-care tasks (dressing, feeding, etc…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Speech/Language/Feeding**

At what age did your child:

Babble (baba, dada) \_\_\_\_\_\_\_\_\_ Speak First Word \_\_\_\_\_\_\_ Combine 2 Words \_\_\_\_\_\_\_\_\_\_\_

Are there any other languages spoken at home? NO YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child eat a variety of foods and textures? YES NO (Please Explain)

Foods Eaten \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Foods Avoided \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any difficulties with eating/drinking? (i.e. choking, coughing) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social & Behavioral**

People Living In the Household

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_ Biological Foster Adopted Step

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_ Biological Foster Adopted Step

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_ Biological Foster Adopted Step

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_ Biological Foster Adopted Step

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_ Biological Foster Adopted Step

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_ Biological Foster Adopted Step

If your child is in school:

Name of school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities does your child enjoy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities/things does your child dislike? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking the time to complete this history form. This information will help in providing the most efficient and accurate evaluation possible. If there are any questions pertaining to the history form, or more specific concerns about your child, please do not hesitate to discuss this with any of the staff as Aspire Therapy. Our goal is to provide you with the most concise and comprehensive evaluation and treatment plan possible.

Again, thank you for your time and effort in completing this form.

Aspire Therapy, PL

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**What to bring to your first appointment**

During your initial visit, we will conduct an evaluation of your child.

Typically, it last one hour. The following is a list of items if applicable to bring to make the evaluation process easier:

* Insurance cards
* Photo id
* Physician referral and prescription
* Copy of current IEP/ISP
* Shoes, tennis shoes and socks
* Glasses
* Aug Com Device

**Preparing for your evaluation**

In order for the evaluation to be the best possible experience, it is important for you and your child to come prepared. Please make sure your child is present and wears comfortable shoes to the evaluation. We do require that your child wears or bring socks for play in the sensory gym for health and sanitary reasons. If your child wears glasses or corrective lens please make sure they wear them. A parent or guardian is expected to be present throughout the entire evaluation, including standardized testing, however, you may be asked to sit outside your child’s field of vision during testing. If you observe within the room, it is important not to break up standardized testing with questions or attempt to correct your child’s behaviors as this may interfere with testing. During the parent or guardian interview, the evaluating therapist will encourage caregivers to ask questions, make comments, or discuss concerns while the child is playing, whenever possible.

What to expect from your evaluation

After the evaluation is completed, your therapist will then discuss whether participation in therapy is necessary and if so give their recommendations for their treatment. Since every child’s specific needs are unique, it can take anywhere from one to two weeks for test to be scored and a formal write up is made. Depending on type of insurance and coverage, the patient may start services within a week. If prior authorization is needed to be obtained, the timeframe can vary from two to four weeks. Aspires office staff will work diligently to make this process run as smooth and expedited as swiftly as possible. Our office staff will work and communicate with you step by step to get services started as soon as all insurance requisites are met.

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Insurance information

**Insurance Disclaimer for All Patients:**  
All insurance information must be disclosed at the time of service. If a patient is covered by one or more insurance plans, it is necessary to provide that information immediately. Any insurance information that is not provided to us within a timely manner that results in non-covered charges will become patient/parent responsibility to pay. Any balance your insurance applies to patient responsibility will be billed to you. For more details, please contact your insurance company.

**How AHCCCS Plans work:**

AHCCCS patients must provide any other information or insurance to the office at the time of service. Any insurance plan that is commercial/private/employer/ sponsored or exchange plan is considered primary to your AHCCCS plan. AHCCCS requires that we bill that insurance prior to billing AHCCCS. If we do not bill your primary insurance first, they will not pay nor process that patient’s claim. Once we bill your primary any amount applied to patient responsibility will be billed to your AHCCCS plan. If it is a covered service the will pay the balance of the claim.

**DDD Policy:**

For every patient that is qualified with DDD, Aspire therapy is required to bill all primary and secondary insurance first before billing DDD for therapy services. Even if we know that the primary insurance will deny the claim we still need to bill them first and provide DDD that information.

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**Patient Contact Consent Form**

Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to be contacted in the following manner:

□ cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave appointment, billing, or medical information on your voicemail?

□ yes □ no

I give Aspire therapy permission to speak and release information to following family or caregivers: (proof of ID needed)

* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Clinic Policies:**

**□⁫⁫** Being late, patient will be seen for what remaining time is left on their time.

□ Please be courteous and cancel over 24hrs. Giving advanced notice gives time for arrangements and reschedules to be made. As well as giving another patient an opportunity.

□ All payments are due upon services rendered unless management has made an arrangement.

□ All children always require supervision. **NO EXCEPTIONS**

It is not safe to allow children to roam unsupervised in the treatment rooms as well as the hallways.

All parents and care givers are required to clean up after their children.

All children are to be escorted to the bathrooms and supervised.

□ No show /No call will be automatic grounds for losing time slot. You may resschedule on a call to call basis.

□ There is no food or drink allowed except for Water.

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INSURANCE LETTER

Dear Parents,

We are pleased to provide therapy services for your child. Please be aware that some insurance companies require that payments for therapy services be issued directly to the insured member and not to the therapy provider. Please ensure that all checks you receive directly for services we provide are signed over and sent to Aspire Therapy upon receipt. In the event that an insurance check is cashed accidentally, a personal check or other payment will need to be issued to Aspire Therapy. If you have any questions, please contact our billing department at 623-977-4911.

Sincerely,

Billing Department Aspire Therapy

By signing/typing my name below, I acknowledge receipt of this notification and will return a copy to the office. Thank you for your assistance in this matter.

Parent/Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today's Date\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(printed)

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(printed)

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**Financial Policy**

**Please initial that you understand the stated policies.**

Billing your Health Insurance Company As a courtesy to you, Aspire Therapy, will bill your insurance company directly after each visit. Insurance benefits vary from plan to plan. Therapy services may not be covered by your insurance or may be limited. Therefore it is the patient’s responsibility to know their individual coverage. While our billing staff constantly tries to stay current, our office does not have the ability to monitor all rapid changes occurring in today’s healthcare environment. We will provide services to your child with the understanding that if any or all the services are not covered by your insurance, you will accept financial responsibility for the services rendered.

\_\_\_\_\_\_\_ **Verification of benefits is not a guarantee of payment**. It is your responsibility to know your insurance benefits as well as you’re in and out of network coverage. It is your responsibility to satisfy your deductible each year by paying the amount directly to us, unless it has been satisfied by payment of other charges. If payment from your insurance company is not received within 60 days of the date of service, payment in full is due immediately or services can be discontinued.

**Payment of fees is your responsibility**

\_\_\_\_\_ I am responsible for all fees and I understand I will be charged for all treatment if not paid by insurance carrier. I agree to pay the yearly deductible and my portion of fees at the time of treatment

\_\_\_\_\_ I understand and agree that co pays/deductibles/co-insurance needs to be paid on the date of service unless prior arrangements with billing dept are made. Co pays/deductibles/co-insurance cannot be reduced. A $25.00 late fee will be added for each unpaid co pay/deductible/co-insurance.

\_\_\_\_\_ I understand and agree that returned payments will result in a $50.00 administration fee.

\_\_\_\_\_ I understand and agree that if an account is sent to collection, Aspire Therapy will charge the patient an additional admin $50.00 fee.