Sandia Sunrise Therapy
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PEDIATRIC NEW PATIENT PAPERWORK

PATIENT INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Sex at Birth: _____ Identified Gender: _____ Preferred Pronouns: _____

GUARDIAN INFORMATION

Legal Guardian: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Mailing Address: _____

City, State, Zip: _____

Occupation/Employer: _____

Legal Guardian: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Mailing Address: _____

City, State, Zip: _____

Occupation/Employer: _____

Who is your child's primary care physician/pediatrician? _____

Which physician/doctor referred you to our office? _____

Who does the child reside with? _____

Who has custody of the child? _____

What is the primary language(s) spoken at home? _____

EMERGENCY CONTACT

Name/Relationship: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Secondary Insurance: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

INSURANCE AND HIPAA ACKNOWLEDGEMENT

Initial the following statements:

_____ I **DO NOT** have any other insurance coverage from any other source other than the above mentioned.

_____ I acknowledged that I have viewed, read, and understand the HIPAA Policy and have been informed of my rights as a guardian.

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS

Initial the following statements:

_____ I give Sandia Sunrise Therapy permission to evaluate and treat my child. I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and Sandia Sunrise Therapy staff.

_____ I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

PHOTO PERMISSION

Initial the following *OPTIONAL* statements:

_____ I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation.

_____ I give permission for photos/video of my child to be used for advertising, brochure, website, and/or social media.

TECHNOLOGY AND ELECTRONIC COMMUNICATION PERMISSION

Initial the following *OPTIONAL* statements:

_____ EMAIL: I give permission to Sandia Sunrise Therapy to correspond with my child's legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that Sandia Sunrise Therapy's e-mail is encrypted internally; however, once an email is sent externally, correspondence may potentially be intercepted by an outside party.

_____ TEXT/VOICE MAIL: I authorize Sandia Sunrise Therapy to send/leave text/voice messages to my phone related to my child's therapy. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from Sandia Sunrise Therapy. I agree not to hold Sandia Sunrise Therapy liable for any electronic messaging charges or fees generated by this service. I understand that Sandia Sunrise Therapy text messages to my cell phone are not secure and potentially could be intercepted by an outside party.

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STATEMENT OF AGREEMENT

EMERGENCY MEDICAL RELEASE

In the event that medical attention is required for your child, while on the premises of Sandia Sunrise Therapy, you authorize Sandia Sunrise Therapy to implement treatment.

MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE

Insurance companies may have limits on the amount therapy services covered. Once you have exhausted this limit, you are responsible for the payment of these services. While this practice will not discontinue services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements. If arrangements are needed, contact our front office.

Not all services are a covered benefit, some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. ***Insurance companies may indicate services were not medically necessary and claim that, because Sandia Sunrise Therapy is a preferred provider, you do not have to pay the balance. This is NOT the case, and you will be billed for services rendered.*** This office cannot accept responsibility for negotiating settlements on disputed claims. You are responsible for checking with your insurance company regarding limits of coverage, fees, and charges.

Should your insurance coverage change, our office must be notified within 30 days of the effective date. If you fail to provide this information, we will no longer bill insurance and future balances will be your responsibility. Payment is due at time of service in full.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with you to resolve past due accounts in all cases. If we cannot reach you by phone following the return of undeliverable mail, or if your payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Let us know when or if your contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT

You authorize payment of medical benefits billed to health insurance by Sandia Sunrise Therapy. You authorize treatment for the forenamed patient and accept responsibility for payment for any service(s) provided that is not covered by health insurance. You agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. You accept responsibility for fees that exceed the payment made by health insurance. If Sandia Sunrise Therapy does not participate with your child's health insurance, you agree to pay all fees and charges for such treatment. You authorize Sandia Sunrise Therapy to use and/or disclose health

information for your child, which can reasonably be used to identify the insured, to carry out treatment, payment, and healthcare operations. You understand that while this consent is voluntary, if you refuse to sign this consent, Sandia Sunrise Therapy can refuse treatment. You understand this authorization can only be revoked in writing. If you revoke consent, such revocation will not affect any actions that Sandia Sunrise Therapy took before receiving my revocation. Any returned checks will be subject to a non-sufficient funds fee of $25.00 which will be due at the next visit. Accounts that are past due will incur a finance charge at the rate of 18% *annually.*

ATTENDANCE POLICY

Our clinic strives to provide the best therapy services possible, and in order to do so effectively, we ask the following:

Discuss schedule changes with your therapist and/or the business office. We understand that sometimes changes are necessary because of illness, vacations, etc. If you need to cancel or reschedule a scheduled appointment, call our office within 24 hours of your scheduled appointment. For Monday morning appointments, notify our office by Friday at noon. If you are running more than 20 minutes late to your appointment, call our office to reschedule.

If a therapy session is not canceled before your scheduled appointment or is missed without any notice, this missed appointment is counted as a no-show and will result in a $35.00 no-show fee**. Insurance companies DO NOT reimburse for no-show fees; this is your responsibility**. Two consecutive no-shows or three no-shows within three months will result in your child being taken off the schedule. We require an 80% attendance rate, which will be monitored monthly. As a courtesy, we will notify you if your percentage falls below 80%. Patients may be removed from the schedule if efforts are not made to maintain this rate.

Let us know if you are experiencing a problem with your current schedule. We are happy to work out scheduling conflicts with you. If therapy needs to be canceled for three weeks or longer, (such as for an extended trip or surgery), we will place your child back on the waitlist and will schedule them when we can. To return to therapy following a medical procedure, a medical release will be required from your doctor.

CLINIC ETIQUETTE

Call our business office from your car and wait for your therapist to bring you and your child inside the building. When joining a session after it has started, check in with the business office first. Be respectful of the end of session time and be ready to pick up your child and speak with your therapist.

Keep odors such as fragrances and strong scents at a minimum as some environmental factors, such as smells, can contribute to sensory overstimulation or allergic responses in children and adults. Refrain from

smoking within 20 feet of the clinic entrance. Therapists have the right to refuse to see patients if the odor is impending their focus and ability to perform effective treatment.

Limit noise and volume when in the clinic as sudden sounds can cause distress to children. Keep electronic use to a minimum and place phones on vibrate or silent. Take phone conversations outside the building, as we do not have a lobby.

Accompany children and those needing assistance or supervision to the restroom, including using the restroom for hand washing. If you have children in diapers or pull-ups, bring a diaper bag to therapy and be prepared to change your child if necessary. Diapers must be thrown in the outside trash.

We discourage bringing toys from home to treatment sessions unless your therapist requests them or permits them. Your therapist will choose toys from our clinic with a specific therapeutic purpose.

Because we work with children with allergies and dietary restrictions, we ask that no outside food be taken into the building. If your therapist needs to incorporate food into the treatment session, they may request that you bring specific foods to your session.

To comply with HIPAA, do not ask therapists about other patients or families at the clinic.

I have read, understand, and agree to the above statement of agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, services could be discontinued.

Guardian's Signature: _____ Date: _____

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MEDICAL AND DEVELOPMENTAL HISTORY

Allergies:	Medication (Name/Dosage):
_____	_____
_____	_____

Has your child been diagnosed by a doctor or psychologist with a developmental, behavioral disorder, or other medical diagnosis?

_____

Has anyone (teacher, pediatrician, friend, relative) suggested your child be evaluated for a specific diagnosis? If yes, what diagnosis?

_____

Difficulties with Pregnancy:		Difficulties with Labor:	
☐ Bedrest ☐ Gestational Diabetes ☐ Pre-Eclampsia Other: _____		_____ _____	
Length of Pregnancy: wks	Delivery: ☐ Vaginal ☐ Caesarian	Length of Labor: hrs	Labor was: ☐ Normal ☐ Induced
Birth Weight: lbs oz	Duration of Hospital Stay Post Birth:		NICU Stay: ☐ Yes ☐ No

Concerns Post Birth:

☐ Jaundice ☐ Colic ☐ Reflux ☐ Feeding ☐ Head Shape/Tilt ☐ Respiratory

Other: _____

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Indicate if your child has ever experienced the following and specify if yes

Condition	Yes or No	Specify		
Hospitalized	Yes ☐ No ☐			
Seizures	Yes ☐ No ☐	Date of First Seizure:	Frequency:	Triggers:
Respiratory/ Lung Difficulties	Yes ☐ No ☐			
Cardiac Problems	Yes ☐ No ☐			
Hip Dysplasia	Yes ☐ No ☐			
Surgery	Yes ☐ No ☐			
Sleep Difficulties	Yes ☐ No ☐			
Poor Weight Gain	Yes ☐ No ☐			
Hearing Problems/ Ear Infections	Yes ☐ No ☐		Tubes? ☐Yes ☐No	Date of Last Screen:
Vision Problems	Yes ☐ No ☐			Date of Last Screen:
Dizziness/Headaches	Yes ☐ No ☐			
Imaging (X-Ray, MRI, CT scan)	Yes ☐ No ☐			
EEG	Yes ☐ No ☐			
Genetic Screen	Yes ☐ No ☐			

List current providers that your child has outside of Sandia Sunrise Therapy

Service	Practice Name	Provider Name	Frequency Seen
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Counselor/Psychologist			
Psychiatrist			
Early Intervention			
Caseworkers/ Case Coordinator			
Dietitian/Nutritionist			
Specialty Doctor			
Other			

Indicate whether your child performed the following skills and indicate approximate age if known

Gross Motor Skill	Age Skill Achieved	Comments
Rolling		
Sitting		

Gross Motor Skill	Age Skill Achieved	Comments
Crawling		
Standing		
Walking		

Circle answers that apply and/or write in answers

Name of Daycare/School:	Grade Level:

Services in School:

☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Social Work/Counseling

Other: _____

Is your child involved in any structured after school/weekend programs (i.e., gymnastics, swimming, soccer, YMCA)?

_____

_____

Is there anything else you would like to share about your child's medical and developmental history that was not listed above?

_____

_____

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TELEHEALTH CONSENT

DEFINITION OF SERVICES

Telehealth is a form of physical therapy, occupational therapy, and/or speech therapy services provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that telehealth involves the communication of medical health information both orally and/or visually. Telehealth has the same purpose or intention as occupational therapy, physical therapy, and speech therapy treatment sessions that are conducted in-person. However, due to the nature of the technology used, I understand that telehealth may be experienced somewhat differently than face- to-face treatment sessions.

RIGHTS AND RISKS

I understand that there are risks participating in telehealth including, but not limited to, the transmission of information could be disrupted by technical failures, the transmission of information could be interrupted by unauthorized persons, the electronic storage of medical information could be accessed by unauthorized persons, and/or services could be disrupted or distorted by unforeseen technical problems.

I understand there is a risk of being overheard by persons if not in a private room while participating in telehealth.

I understand that the dissemination of any personally identifiable images or information from telehealth interaction shall not occur without written consent.

The laws that protect the confidentiality of medical information also apply to telehealth. I have the right to withhold or withdraw consent at any time without affecting the right to future care or treatment.

PATIENT RESPONSIBILITIES

Providing the necessary computer, telecommunication equipment, and secure internet access (password protected) for telehealth session.

Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for telehealth session.

Providing support and being present during the session when requested by the therapist. Communicating with the therapist any concerns or technical difficulties.

SANDIA SUNRISE THERAPY RESPONSIBILITIES

Having the necessary equipment and secure internet access (password protected) for the telehealth session.

Having high encryption and secure technology.

Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for the telehealth session.

Informing individual and/or caregiver of materials needed for the session prior to beginning the telehealth session.

Using HIPPA compliant platform to provide services. Currently, Sandia Sunrise Therapy is using Fusion Web Clinic Telehealth. Should the clinic change their telehealth platform, patients will be notified in advance.

Informing caregivers if they would be better served by another form of therapeutic services (i.e. face-to-face services).

I have reviewed the above information and agree to the terms stated in the Telehealth Consent.

Patient's Name: _____ Caregiver's Name: _____

Caregiver's Signature: _____ Date: _____