New Beginning Pediatric Rehab
~ Maryland's Trusted Rehabilitation Practice ~
(410)796-8499 Office • (877)384-9028 Fax
www.newbeginningpediatric.com

PATIENT/PARENT INFORMATION

Patient Full Name: _____ Patient's Date of Birth: _____

Parent(s) Name: _____ Cell Number: _____

Address: _____ Home Number: _____

_____ Email: _____

How did you hear of us? _____
(Physician,Google,Friend,Facebook,Other)

Authorized method of communication with you relative to appointments, plan of care, & financial matters (check all that apply) :

Email ☐Yes ☐No **Text** ☐Yes ☐No **Phone** ☐Yes ☐No **Mail** ☐Yes ☐No

Referring Physician: _____ Pediatrician: _____

Address: _____ Pediatrician Phone: _____

_____

Phone: _____

INSURANCE INFORMATION

Is your child covered by only one plan? ☐ Yes ☐ No (If no, please list both plans)

Insurance Company: _____ Phone number: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Number: _____ Policy Holder's DOB: _____

Group Number: _____

Employer Name: _____ Employer Address _____

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CONSENT FOR MEDICAL CARE & TREATMENT

PATIENT NAME: _____

My child is being treated at New Beginning Pediatric Rehab ("NBPR") for a condition requiring treatment. I consent to all medical care and tests determined by my therapist that are necessary for my child. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of care. I also understand that if I do not follow my therapist's recommendations as they may relate to my child's health that the therapist and this Office will not be responsible for any injuries or damages that are the result of my non-compliance.

A. Such treatment encompassing procedures and medical treatments as ordered by _____ who is my child's ordering physician. I authorize NBPR and their designated representatives permission to communicate & coordinate my child's care with the following:

Pediatrician:	Name_____	Phone:_____	Specialty_____
Other Physician:	Name_____	Phone:_____	Specialty_____
School System Therapist(s):	Name_____	Phone:_____	Specialty_____
	Name_____	Phone:_____	Specialty_____
School System Employee(s)	Name_____	Phone:_____	Specialty_____
Relative:	Name_____	Phone:_____	Relation _____

B. I authorize NBPR and their designated representative(s) to communicate with those mentioned above as it relates to my child's care: (check all that apply) :

Email ☐Yes ☐No **Text** ☐Yes ☐No **Phone** ☐Yes ☐No **Mail** ☐Yes ☐No

C. I authorize and request my child's ordering physician and New Beginning Pediatric Rehab, Inc. to release all information concerning my child's case history, care and treatment while being cared for by New Beginning Pediatric Rehab, Inc. These records, or review of same can be released to representatives of my insurance company or any other third party source of payment responsible for my bill

D. I understand that NBPR does NOT provide emergency medical care and will call 911 in an emergency situation.

Signature of
Patient's Legal Representative_____ Date_____

Printed name of
Patient's Legal Representative _____

Relationship of
Legal Representative to Patient _____
(e.g., parent, guardian, other, ...)

E. Emergency Contact:_____ Relationship:_____ Phone: _____

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PATIENT RESPONSIBILITY POLICY

We are committed to providing quality healthcare services to our patients. To ensure a smooth and efficient healthcare experience for both our patients and our staff, it is essential that patients understand and adhere to their responsibilities. This Patient Responsibility Policy outlines the expectations and obligations of patients receiving care at our medical practice.

PART 1: INSURANCE & PAYMENT POLICIES
PART 2: ATTENDANCE & CANCELLATION AGREEMENT
PART 3: PATIENT & PARENT/CAREGIVER CONDUCT AGREEMENT

Please acknowledgement your understanding of these policies by initialing, signing and dating where applicable:

PART 1: INSURANCE & PAYMENT POLICIES

Insurance: Patients are responsible for providing current and accurate insurance information, including any changes to your plan. Failure to notify the administration office of changes to your insurance may result in claim denials and the policyholder will be responsible for any denied visits. It is the patient's responsibility to understand their insurance coverage, including co-payments, deductibles, and any other financial responsibilities. We encourage you to verify your benefits with your insurer prior to services being rendered.

Billing Service: As a courtesy to patients, claims will be submitted to your insurance carrier by NBPR on your behalf. NBPR does not guarantee payment of any services by your insurance carrier. NBPR will issue you an invoice after your insurer processes the claims (approximately 35-45 business days after the date of service).

Assignment of Benefits: I hereby assign to and authorize payment of all insurance related reimbursement available to me directly to NBPR for services provided to me.

Financial Responsibility: I understand and agree that I am ultimately financially responsible for payment of all charges incurred including deductibles, co-payments, co-insurance, & non-covered services/supplies.

Payment Method & Responsibility: A valid credit card (MC & Visa), or ACH account information, is required to be on file prior to services being rendered. You will receive access to your online account where you will receive relevant account information, including payments and invoices. As a courtesy. we will waive any credit related services charges incurred by the credit card processor. If your automatic payment declined, you are required to make payment within **5 days of receiving our invoice**. We may charge a **$25.00 late fee** for each unpaid invoice that exceeds 30 days past due. Repeated delinquency of payment (2 offenses greater than 30 days past due) will result in removal from scheduled appointments without an option to return to NBPR for services in the future. Failure to provide timely payment is a violation of this agreement and the agreement with your insurance company. Continued failure of payment will result in further collection efforts.

Denied Services: As a courtesy, NBPR will submit one appeal for denied services/supplies on the patient's behalf. If your insurer denies our appeal, payment in full is expected within 5 days of the appeal denial. Any additional appeals will be the patient's responsibility.

Required method of payment:

_____ Acknowledgement (Initial). I have read and understand policy Part 1.

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PART 2: ATTENDANCE & CANCELLATION AGREEMENT

Attendance Policy: Appointments with NBPR require consistency for progress to occur. Your therapist reserves a dedicated block of time in their schedule for your child's care. Missed appointments cannot be filled by another patient within a short window of time and cannot be billed to your insurance carrier. Repeat cancellations will result in discharge from care due to the negative impact they cause relative to your child's progress including the negative impact for those children on our wait list.

Attendance & Repeat Cancellation:

- Attendance requirement: A consistent 75% attendance rate is required over 30 days to stay on the schedule of reserved appointments.
- A maximum of 3 cancellations, or 2 no-shows (failing to show at scheduled time without contacting the therapist) FOR ANY REASON (including illness), will result in removal from the schedule of reserved appointments.
- Repeat cancellations or no shows will result in removal from the reserved schedule of appointments. **In some situations, if repeat cancellations are due to repeat illness we may offer the option to change status from "reserved schedule of appointments" to "cancellation call list".
- A **24 hour notice is required to prevent incurring an $85 charge**; however a minimum of 48 hour notice or more is requested by our therapists. (please keep your therapist number and email handy)
- Thank you for your courtesy in following this policy.

PART 3: PATIENT & PARENT/CAREGIVER CONDUCT AGREEMENT

Remain on property policy:

- As with most healthcare facilities, parents/caregivers **MUST** remain on the property **AT ALL TIMES** during their child's session. This policy is in place to ensure the child's safety and timely transition and release to the parent/caregiver.
- Disregard of this policy will lead to immediate discharge from services without the option to return.
- Please notify your child's nannies and other caregivers of this policy.

Common situations that may cause discontinuance of services:

- Plateau of progress x 2 months. This demonstrates therapy is no longer beneficial at this time.
- Parental goals and therapist recommendations are no longer in alignment.
- The patient demonstrates a pattern of elopement during treatment sessions. This causes a safety risk for the patient and others.
- The patient demonstrates harmful behaviors towards self, staff or other patients.
- Pattern of bathroom accidents during sessions will result in a halt in therapy sessions until this challenge is mitigated.
- Difficulty with transitioning from the car to/from sessions causing significant disruptions of treatment goals for themselves or other patients.
- Social/emotional barriers that might impact the success of a treatment plan. (ie. the patient may be reluctant to participate in sessions)
- Delinquent account status - see financial policies.

Compliance with Treatment Plans: Patients are responsible for following the prescribed treatment plans recommended by their healthcare provider. This includes attending follow-up appointments, diagnostic tests, and consultations as scheduled.

_____ Acknowledgement (Initial). I have read and understand policy Part 2 & 3.

Review and Revision: This Patient Responsibility Policy will be reviewed periodically and updated as needed. Patients will be informed of any changes to the policy.

By receiving care at New Beginning Pediatric Rehab, patients &/or their parent(s), acknowledge that they have read, understood, and agree to comply with the Patient Responsibility Policy.

_____ _____

Patient Name: Please print **Parent/Guarantor Signature** **Date**

Please Return to NBPR Admin Office:

Fax: 877-384-9028 or Email: laura@newbeginningpediatric.com

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CREDIT CARD AUTHORIZATION

Name on Card: _____

Card Type: ☐ VISA ☐ M/C
(circle one)

Account Number: _____ Expiration (Mo/Year): _____

CVV 3 or 4 digit: _____

E-mail address: _____

Patient Name: _____

I agree and authorize New Beginning Pediatric Rehab Inc. to charge the above account for all co-payment, deductible, & co-insurance as dictated by your insurance provider including non-covered services & private/non-insurance related services.

Authorized Signer: _____ Date: _____

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Single Family Household (check box) ☐YES☐NO If NO what is custody arrangement: _____

Living Situation: _____

Siblings: _____ Age: _____

_____ Age: _____

_____ Age: _____

Current or ongoing concerns/reason for referral:

MEDICAL INFORMATION:
Diagnoses (list all current & date of diagnosis) :

CURRENT CONDITION:
Please complete the followng:

Date of last physical exam: _____ Current weight: _____ Current height:_____

Current Medications/Dosage/Frequency: _____

My child currently sleeps/naps: ☐ inconsistently ☐ well ☐ restless ☐ other

My child currently eats/drinks: ☐ at regular/irregular intervals ☐ consistent/inconsistent amounts

Known Allergies/Diet Restrictions: _____

Are immunizations up to date? ☐ Yes ☐ No _____

History of major illnesses/hospitalizations: _____

Does your child have a feeding tube or require a ventilator to breathe? _____

History of ear infections? Yes ☐ No ☐ If yes, how many:_____

Date of most recent hearing test: _____ Results: _____

Where was the test conducted? ☐ School ☐ Doctor ☐ Audiologist

Does your child wear hearing aids? Yes☐No☐ Describe hearing loss:_____

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Date of most recent vision screening: _____ Results:_____

Please describe any vision impairment: _____

How does your child currently move in his/her environment? _____

Any diagnosed mental, emotional, or learning disabilities? _____

Any concerns about physical, sexual, mental, or emotional abuse? _____

Describe your child's current demeanor: (Are they generally happy? Tend to be active? Easily frustrated or have trouble with changes in routine? Do they make friends easily? What are their favorite or most challenging activities?)

_____

_____

_____

Does your child receive behavior therapy or have they received behavior therapy in the past? If yes, please elaborate.

_____

_____

PREVIOUS & CURRENT THERAPIES AND/OR SPECIALISTS: please list names, types and dates seen. If applicable, please provide copies of relevant evaluations and reports (occupational therapy, speech-language therapy, psychoeducational, neurological, IEPs, etc.)

_____

_____

_____

_____

_____

_____

_____

DEVELOPMENTAL INFORMATION
MOTHER'S HEALTH DURING PREGNANCY: *Please circle Yes or No to the following questions and remark in the space provided.*

1. Were any drugs or medications taken during pregnancy? Yes☐ No☐_____
2. Was the pregnancy full-term? Yes☐ No☐_____
3. Was the delivery normal? Yes☐ No☐ If no, please specify (cesarean section, breech, cord around neck, forceps used):

   _____

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CHILDS BIRTH: *Please circle all that apply and/or fill in the blanks.*

1. Child's weight at birth: _____ Length of infant's hospital stay: _____
2. Was your infant admitted to the NICU? Yes☐ No☐ If yes, length of stay? _____
3. Were there any complications? ☐Seizures ☐ jaundice ☐ congenital defects ☐ other: _____
4. Was there a need for: ☐oxygen ☐transfusions ☐tube feedings ☐other:_____
5. Was the child breast fed or bottle fed? _____ When weaned? _____
6. Did the infant have any feeding problems? _____
7. Describe your child's demeanor and behavior as an infant: _____
8. Has your child had a tongue tie correction surgery?☐Yes ☐No If yes, at what age? _____

DEVELOPMENTAL MILESTONES:
Please list the age (in months) at which your child did the following and answer the questions that follow.

Roll _____ Sit _____ Belly crawl _____ Crawl on hands/knees _____ Walk _____ Stand _____

Run _____ Skip _____ Say first word _____ Finger feed _____ Use spoon/fork _____

Sleep through night _____ Drink from cup _____ Dress independently _____

1. Any concerns or questions about your child's development?_____

_____

2. When did your child gain bladder control? _____ Bowel control? _____

SOCIAL/EDUCATIONAL HISTORY:

School/Day Care: _____ Grade: _____

Teacher's Name: _____ Phone: _____

Activities your child enjoys at home or school :

_____

_____

_____

Does your child prefer to do these activities alone or with other children/siblings? _____

Are you confident your child's current school is meeting your child's needs? ☐ YES ☐ NO (*please elaborate)*

_____

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WHAT ARE THE THREE OR FOUR MOST IMPORTANT GOALS YOU WISH TO HAVE ADDRESSED DURING YOUR CHILD'S THERAPY PROGRAM?

_____

_____

_____

_____

_____

PLEASE USE SPACE BELOW FOR FURTHER COMMENTS OR SHARING ANYTHING YOU THINK WE SHOULD KNOW ABOUT YOUR CHILD:

_____

_____

_____

_____

_____

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POLICIES FOR SIGNATURE

*In cases of separation and/or joint custody, legal documentation of custody arrangements must be provided prior to services and both parents/guardians must sign signature forms.

Client Name: _____ **DOB:** _____

Please review and sign the following:

Acknowledgement of Notice of Privacy Practices

I acknowledge the NBPR will use and disclose my child's personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I further acknowledge that NBPR Notice of Privacy Practices, which is available at the initial appointment and/or upon request, provides further detailed information about how NBPR may use/and or disclose protected medical information about my child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Client/Parent or Guardian Signature Date

Photograph and Video Release Form

NBPR is a private practice, focusing on interventions with people of all ages, but most of children. Additionally, this practice is involved in the education of future therapists. As such, we may take photographs or videos of children or family members participating in services. The photographs and videos may include interviews, assessments, interventions, and/or other clinical activities. The rights, titles, and interest of these materials belong to NBPR, which reserves the right to edit the material.

I _____ (please print name) voluntarily consent to the taking of videos or photographs of myself or my child _____ (print child's name)

I understand that these photographs or videos may be used for educational purposes, intervention purposes, and/or media purposes in education training programs or media publications. I understand that the photographs or videos may be used to create education training videos and may be used by NBPR for seminars, staff/student training, workshops or on the NBPR website or social media page(s). Some video or photographic material may be included in future training videos.. Specific names of children and other family members will not be used in photographs or videos without separate consent.

I give permission for the use of photographs or videos for educational purposes, for news or other media, for NBPR website & social media and for training videos.

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Client/Parent or Guardian Signature Date

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Frequently Asked Questions - Treatment Area Policies

WE LOVE ALL OUR PATIENTS AND THEIR FAMILIES!

We appreciate your help as we strive to maintain a therapeutic environment for our patients.

1. May I drop my child off for therapy, leave, and then pick them up at the end of their session? NO, DROP OFF IS NOT ALLOWED. PARENTS ARE REQUIRED TO REMAIN ON PROPERTY DURING THERAPY SESSIONS.

2. Do I need to stay in the treatment area with my child during their therapy sessions? No, a parent does not need to stay in the treatment area with their child during therapy sessions unless your therapist requests you be present for discussion and instruction. To minimize distractions and maximize therapy sessions we suggest parents stay in the waiting area for patients 18months and older.

NOTE: All treatment plans are individualized so please ask your therapist what arrangement works best for your child. Also please keep in mind circumstances may vary among patients. We appreciate your understanding.

3. How many parents/guardians are allowed in the Therapy Gym at one time? To minimize distractions and maximize therapy sessions we respectfully request only ONE parent per patient in the Therapy Gym or "common" areas at a time. Please provide your therapist notice if more than one parent or family member will be attending therapy so a treatment room can be reserved.

4. Is it ok to bring siblings to therapy sessions? Yes, this is allowed but not encouraged. We recommend other arrangements be made for siblings whenever possible. If a sibling needs to come along we require a parent stay in the waiting area to supervise any sibling 12 and under. If a sibling must be present in the treatment area during a therapy session please notify your therapist prior to your visit to allow the therapist time to reserve a treatment room.

5. My son has therapy today however his sister is home from school due to illness. Can I still bring my son to therapy and wait in the waiting room with my daughter? Please keep sick children at home. For the health and safety of our patients and staff the illness policy applies to ALL children, including siblings. NBPR Illness Policy - Please contact your therapist and cancel if your child is suffering from any of the following: Uncontrollable symptoms of coughing, sneezing and runny nose; fever of 100 degrees; bad cold with thick green discharge; vomiting or diarrhea; strep throat that has not been treated at least 48 hours; pinkeye, lice, chickenpox, or anything else very contagious. PLEASE REVIEW OUR CANCELLATION POLICY.

6. Do you have a Hand Washing Policy? Yes. We require ALL patients wash their hands before sessions with soap or hand sanitizer. Hand sanitizer is available throughout the clinic and soap is available in the lavatory.

7. What is the NBPR Cell Phone Policy? Cell phone usage should not disturb those around you. The privacy of patients and staff must be respected. No photos or videos.

THANK YOU FOR YOUR COURTESY,

NEW BEGINNING PEDIATRIC REHAB STAFF

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.

1. Uses and Disclosures. We will use your protected health information **(PHI)** for the purposes of treatment, payment and health care operations.

Coordination of Care: PHI will be shared with other health care professionals in order to effectively manage care of the patient. This may include doctors, nurses, technicians and other health care providers.

Payment: Insurance companies require PHI in order to process payments on your behalf for services rendered. Your insurance company may request a review of your medical record to determine medical necessity.

Uses and Disclosures Required by Law: The federal health information privacy regulations either permit or require us to use or disclose the patient's PHI in the following ways: we may share some of the patient's PHI with a family member or friend involved in the care if you do not object. We may use your PHI in an emergency situation when the patient may not be able to express themselves. We may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

Authorization by the patient or legal guardian is required before your PHI may be used or disclosed by us for other purposes.

2. Your Privacy Rights

Restrictions : You have the right to request restrictions on how the patient's PHI is used, however we are not required to agree with the request. If we do agree, we must abide by the request.

Confidential Communications: The patient and/or legal guardian have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI: The patient and/or legal guardian have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments: You have the right to request an amendment be made to your PHI, if you disagree with what it says. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Complaints: If you feel that your privacy rights have been violated, the patient and/or guardian has the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy: We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Our Notice of Privacy Practices is posted on our website at www.newbeginningpediatric.com.

Privacy Contact: If you would like more information about our privacy practices you may contact:

Shari Marchese-Kennedy, MPT
Privacy Office
President

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