# Building Block Pediatric Therapies of Illinois, LLC

## New Client Check List

Dear Parents:

We would like to welcome you to Building Block Pediatric Therapies of Illinois LLC, we look forward to working closely with your child and your family. Please return this completed packet so we may begin to enroll your child in a timely manner. We must have all of your forms, medical, and financial information, at least two days prior to the start of services or we may need to reschedule you first visit.

You are encouraged to contact us with any questions/concerns you might have. **Please return your paperwork by email, by US mail, fax, or drop it off at any time.** Make sure all enclosed forms are signed, dated and completed to the best of your knowledge.

## Check List

- New Patient Information
- Emergency Treatment Release/Picture-Park Release
- Notice of Privacy Practices
- Assignment of Benefits, Medical Records Release HIPAA Acknowledgement
- Financial Policy Acknowledgement
- Case History Questionnaire

If your child has received speech therapy, physical therapy, occupational therapy or behavioral health services in the past, please include a copy of the initial evaluation or progress notes from the attending clinician. If your child is currently receiving an IEP or 504c plan through the school system, please notify your therapist of the existing plan with your child's goals and benchmarks.

**Thank you for choosing Building Block Pediatric Therapies of Illinois, LLC**

# Building Block Pediatric Therapies of Illinois, LLC


## New Patient Information

Please print the following information. Avoid delays by answering question completely.

***Patient Identification (Please Print)***

**Child's Name**: _____

Birth Date: _____ Sex: _____ Age: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Primary Care Physician: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Current School: _____

City/State: _____

***Family Information***

**Father's Name**: _____

Home Address (if different): _____

Employer: _____ Work/Cell Phone: _____

Work Address: _____

Email Address: _____

**Mother's Name**: _____

Home Address (if different): _____

Employer: _____ Work/Cell Phone: _____

Work Address: _____

Email Address: _____

**Marital Status of Parents:**

Married _____ Single _____ Separated _____ Divorced _____

**Legal Guardian (if different):**

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Cell: _____

Email Address: _____

# Building Block Pediatric Therapies of Illinois, LLC

## Emergency Treatment Release & Picture Release

Child's Name: _____ DOB: _____ Date: / /

As a parent &/or guardian, I do authorize the treatment by a qualified medical doctor for the above minor in the event of a medical emergency which, in the opinion of the physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. Please list any medical conditions: Please specify any medical conditions which would be important to inform medical personnel in an emergency, allergies, heart condition, diabetes, seizure disorder, medications etc.

_____

_____

_____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Emergency contacts in order of preference:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

## Picture/Video Release

I give permission for my child's picture/video to be used by BBT, LLC for the purpose of

☐ Training & collaborating with other professionals

☐ Marketing/publicity (poster, website, flyers etc. ☐ No, None of the above

## Dietary information/food release:

☐ My child may participate in snack. Please list the restrictions:

_____

☐ NO! I do not authorize a snack.

## Park/Outside Release

I do ☐ I do not ☐ give authorization for my child to work on therapeutic goals outside of the clinic rooms on the front parkway grass or a playground when accompanied by a therapist.

_____ _____

*Parent/Guardian Signature* *Date*

_____ _____

*Parent/Guardian Signature* *Date*

# Building Block Pediatric Therapies of Illinois, LLC

## Financial Policy Acknowledgement 2014

***The purpose of this letter is to establish a standard operating procedure for our company. Because we are a small company it is mandatory that we have this policy in effect.***

Our Thanks: Thank you for choosing BBT of Il, LLC as your child's therapy provider. We look forward to working closely with your child and your family. Your clear understanding of our payment policies is important to our professional relationship before beginning therapy services.

PAYMENT: Full payment of co-payment and/or coinsurance is due ***at the time of sign-in.*** We accept cash, checks, Visa, and MasterCard. **A current credit card number and signature must always remain on file**. If payment is not received at the time of service, your credit card will automatically be billed at the end of the month. If you fail to meet your financial obligations, you will be responsible for the balance on your account and all collection fees incurred. An account will go into collection after a 90-day delinquent period. Collection fees are 33.34%.

INSURANCE & CLAIMS: **Having an insurance plan does not guarantee coverage for our services.** Once your insurance company has paid its share; you will be responsible for any remaining balance. If your insurance company declined coverage for your services, you will be responsible for your balance. You are responsible for knowing if we are in your plan and for fulfilling the requirements of your policy - referrals, co-payments, pre-certifications, etc.

MISSED APPOINTMENTS: Appointments missed without advance notice will be billed a $75.00 fee. Please call to cancel an appointment at least 24 hours in advance. Late arrival to an appointment will not adjust the scheduled time or fee billed.

*Credit Card Information*

**Patient Name: _____**

**Date: _____**

**I understand that my credit card will be charged at the end of each month.**

Credit Card (circle one): VISA MASTERCARD

Name as it appears on the card:

_____

Credit Card Number: _____CVC Code: _____

Expiration Month/Year: _____

Billing Address Zip Code: _____ is this an FSA/HSA account: Yes No (please circle)

Authorized Signature: _____ Date: _____

# Building Block Pediatric Therapies of Illinois, LLC

## BBT, LLC Patient Agreement

### Assignment of Benefits, Medical Records Release HIPAA Acknowledgement

| Patient's Name | Date of Birth | Date |
|---|---|---|
| | | |

**AUTHORIZATIONS FOR DISCLOSURE OF MEDICAL INFORMATION**

**I hereby authorize BBT to release any information required in the processing of application for financial coverage for services rendered.** This authorization provides that Building Block Pediatric Therapies, LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent for the purpose of enabling that insurance company or health care service plan corporation to evaluate my claims or its liability under such policies or contracts or coordinating benefits pursuant to such policy or contract provisions. BBT has informed me and provided me with a copy of my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE**

I hereby authorize payment to be made directly to the BBT, LLC for insurance benefits payable to me. **I understand that I am financially responsible to BBT, LLC for any covered or non-covered service,** as defined by my insurer, which are not paid by my primary or secondary insurer.

**Please list persons/organizations to receive information from Building Block Pediatric Therapies of Illinois, LLC regarding treatment, payment and/or health care operations:**

_____

_____

_____

_____

- **I may revoke this authorization at any time by notifying BBT, LLC in writing.**
- **My signature authorizes BBT to share information with the prescribing physician.**

_____ _____

(Authorizing Signature) (Relationship) (Date)

# Building Block Pediatric Therapies of Illinois, LLC

## NOTICE OF PRIVACY PRACTICES

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information.
- You have the right to request to receive confidential communications of protected health information from us. We must respond within 30 days of your request.
- The right to inspect and copy your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Breach notification requirements – We are obligated to notify patients if there is a breach of your PHI or any information within 10 days of incident by mail.

Building Block Pediatric Therapies, LLC will never use any of your information for marketing purposes/communications, unless you have signed a waiver to do so. This is a separate form available from our front office. To clarify we are prohibited to sell a patient's PHI in the absence of the patient's written authorization. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact for more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services (877)-596-6775

Office of Civil Rights, 200 Independence Avenue, S.W., Washington D.C. 20201