Cynthia Miles & Associates LLC.

Date

Child's Full Name Birth Date

Home Address City State Zip Code

Child's Social Security # (______) Home Phone #

Mother's Full Name Birth Date

Home Address City State Zip Code

Mother's Social Security # (______) Home Phone #

(______) Work Phone # (______) Cell Phone # Email

Employer's Name & Address

Father's Full Name Birth Date

Home Address City State Zip Code

Father's Social Security # (______) Home Phone #

(______) Work Phone # (______) Cell Phone # Email

Employer's Name & Address

Emergency Contact Name (______) Home Phone # (______) Cell Phone #

Referring Physician Physician's Phone

Reason for Referral Diagnosis

Family Physician Family Physician Phone #

Orthopedist Neurologist

Has child ever been treated for torticollis? Yes/No

Allergies

Surgical / Illness History

Other Programs and Related Services

Siblings Name / Age

Current Patient Information:

Gender: **M/ F** Race:__________________________ Weight:______ Length:________________

Height/Weight Percentile:_________ Head Circumference:_____________ Apgars:_________ Birth Order:______

Was child born prematurely? **Yes / No** If yes: Chronological Age:___________ Gestational Age:_______________

Was child breastfed? **Yes / No** Mom's age at time of birth: ____

Where was your child born?

Name of Hospital:____

Who was your Ob/Gyn:____

Name of Birth Center:____

Home: ____

Weight at Birth:_______________ Length at Birth: ______________ Length of Hospital Stay:_________________

Type of Delivery: __________________ Utero Position:______________ Attendance at a Pre-Natal Class: **Yes** / **No**

Births: **Single / Multiple** If multiple how many? ____

List any complications during pregnancy (bed rest/low back pain/ leg pain):____________________________________

____

List any complications during delivery:____

____

List any medications taken by mother during pregnancy:____

____

List any medications taken by mother during delivery:____

____

Was your child admitted to NICU or did he/she remain in newborn nursery?__________________________________

Did your child receive physical therapy services prior to returning home (in NICU, PICU, or nursery)?_____________

____

Child's Sleep Position: __Supine (on back) __Side __Prone (on tummy) __Other:___________________
Explain

If applicable, does your child snore? **Yes / No** Does your child have frequent ear infections? **Yes / No**

Please list the age of child at the following milestones (in months):

Started walking:_____ Started talking:______ Eating Table Food:_________

Mouthing of toys/hands:_____ Cereal introduced:____ Pacifier use:_________

What kind of food/formula does your child eat?____

____

How does your child typically communicate? gestures / single words / short phrases / sentences **Circle one**

Is your child understood by others or just family members?____

Where do you generally seek information on your child's development?_________________________________

____

Emergency Treatment Permission

I give my permission for a staff member of Cynthia Miles & Associates to take me and/or my child to a Hospital Emergency Room for me and/or my child's Treatment if the need for Emergency Care arises. I hereby give my permission for the staff member to respond by activating EMS (Dialing 911), Initiating Rescue Breathing and/or Basic CPR Procedures and/or Basic First Aid if appropriate. I therefore accept full responsibility for whatever consequences may occur and hold Cynthia Miles & Associates to **NO** Legal or Medical Liabilities.

Signed:____________________________________ Date:___________________________

Child's Name:____

************************************OR***************************************

I have read the above stated emergency permission statement and **DO NOT** grant staff members of Cynthia Miles & Associates permission to initiate Basic Emergency Procedures in the event that a staff member would be present during a medical emergency in which I, myself, was unable to perform necessary Emergency Procedures. I therefore accept FULL Responsibility for whatever consequences may occur and Hold Cynthia Miles & Associates to **NO** Legal or Medical Liabilities.

Signed:____________________________________ Date:______________________

Child's Name: ____

*Special Instruction or Restrictions:____

____

____

Consent to Obtain or Release Information

I authorize Cynthia Miles & Associates to obtain or release information regarding my son/daughter

________________________________ Date of Birth:_______________________________

This information exchange is of the purpose of providing Physical, Occupational, Speech Therapy and/or Special Instruction Programs which will meet the needs of my child. This includes providing treatment, procuring payment and conducting health care operations. I understand that in order to protect confidentiality of records, my agreement to obtain or release information is necessary. The information will only be shared as necessary to provide quality treatment and communication between your primary Health Care, Educational, and Payment Providers. I understand that by written statement, to Cynthia Miles & Associates, I may withdraw my permission at any time.

This consent will be in effect throughout the duration of my child's treatment regime. It is effective for all Physical, Occupational, Speech Therapists and teachers at Cynthia Miles & Associates who treat and/or have contact with my child.

Please be advised we make every effort to maintain strict confidentiality for all of our clients. However, due to our open concept design, information about your child may be overheard.

Permission to Photograph your child:	Yes_______	No________
Permission to display photograph of your child:	Yes_______	No________
Permission to video tape your child:	Yes_______	No________

Parent/Guardian____ Date:___________

OPTIONAL: This release of information or ability to obtain information is Limited to the following:

____

____

Cynthia Miles & Associates LLC.

Insurance Information

Primary Insurance
Company:____

Policy Number: _______________________ Policy Holder: Birthday_________________Mother/Father
(Circle One)

Address:____

____

Secondary Insurance
Company:____

Policy Number: _______________________ Policy Holder: Birthday_________________Mother/Father
(Circle One)

Address:____

____

Additional Insurance Information:____
Policy Number: _______________________ Policy Holder: Mother/Father/Child
(Circle One)

Address:____

____

I herby authorize my insurance company/companies to pay proceeds of any benefit due me directly to Cynthia Miles, Med., PT, PCS.

I herby agree to pay my account for services rendered, the percentage not covered by my insurance. If for any reason a balance is owing on my account, I agree to pay that promptly upon receipt of the statement.

Although I have requested Cynthia Miles & Associates to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid in a reasonable amount of time. If for any reason any portion is not paid by my insurance, I agree to make arrangements for the prompt payment of the bill in full.

I have read the PAYMENT POLICY & Insurance Payment Policy and understand all my responsibilities. The payment policy remains in effect for all visits and charges, including my first and all future visits.

I understand all coasts related to collection and legal fees for procurement of payment will be the direct responsibility of the patient/patient's parents/guardians.

Signature:____ Date:___________________________

Cynthia Miles & Associates LLC.

Insurance Payment Policy

Our office makes every attempt to accept and work with most insurance companies. We participate with the following insurance companies:

- AETNA U.S. HEALTHCARE
- CAPITAL BLUE CROSS
- PENNSYLVANIA BLUE SHIELD
- KEYSTONE HEALTH PLAN CENTRAL
- KEYSTONE HEALTH PLAN EAST
- UNITEDHEALTH CARE
- CHAMPUS
- INTERCOUNTY HEALTH PLAN
- BLAIR MILLS
- ACCESS-MEDICIAL ASSISSTANCE
- HMOS FOR MEDICAL ASSISTANCE: AMERIHEALTH MERCY; GATEWAY; THREE RIVERS MEDI-PLUS
- MEDICARE
- LEHIGH/NORTHAMPTON COUNTIES EARLT INTERVENTION

PLEASE NOTE: Insurance Benefits are **NOT a guarantee of payment for services. The subscriber will be billed for any unpaid claims.

BILLING

Billing for dates of serves is done monthly, in most cases, directly to insurance companies. We make every attempt to contact your insurance company and provide billing services. However; **please keep in mind that the ultimate responsibility for payment and negotiation with the insurance company falls on the parents/subscriber**. We will do our best to help you understand the insurance process as much as possible. Our office staff will attempt to assist you with any of your insurance questions.

It is the subscriber's ultimate responsibility to keep our office informed of insurance changes to your policy and keep us updated on your insurance information.

MEDICAL ASSISTANCE & MEDICAL ASSISTANCE HMO's (Gateway & AmeriHealth Mercy)
(The following applies to both Medical Assistance & Medical Assistance HMO's)

At this time; We accept Medical Assistance and or Medical Assistance HMOs as a primary and secondary payer only for Physical Therapy services. Medical assistance is always secondary to your primary insurance. Please Not: we must always bill your primary insurance first before billing Medical Assistance. Co-pay and Deductible with Medical Assistance: The Medical Assistance payment rate is lower than commercial insurance and or Medicare. Your co-pay and deductible are write-offs for our office. Medical Assistance **DOES NOT PAY YOUR CO-PAY or CO-INSURANCE**. For example: if we bill a code at $35 and your insurance allows $15, but Medical Assistance allows $8, the $20 dollar difference becomes a write-off, for us. Presently, we will continue to accept Medical Assistance for Occupational and Speech Therapy as a write-off for your co-pay and deductible. We **cannot** accept Medical Assistance as a primary for Occupational and Speech Therapy due to payments made by Medical Assistance. They are as follows:

- Occupational Therapy - $ 6.25 per 15 minute unit ($25.00 per hour)
- Speech Therapy – $21.70 per day (payment is same if child is treated for 15 minutes or one hour or more)

Any questions on this matter please see either Cindy or Fran Schlofer.

It is the subscriber's ultimate responsibility to keep our office informed of insurance changes to your policy and keep us updated on your insurance information. **IF YOU FAIL TO KEEP OUR OFFICE INFORMED OF CHANGES TO YOUR INSURANCE, WE ARE UNABLE TO BILL MEDICAL ASSITANCE AS YOUR SECONDARY. The subscriber will be billed for any unpaid claims.**

**It is the subscriber's responsibility to obtain an appropriate Diagnosis from a Medical Doctor.
*The subscriber is responsible for knowing if Insurance covers therapy for prescribed diagnosis.
Cynthia Miles & Associates does **NOT** diagnosis patients.

Cynthia Miles & Associates LLC.

PAYMENT POLICY

PAYMENT IS DUE AT TIME OF SERVICE unless we are participating providers with your insurance companies.

Payment Options if we are NOT participating providers:
1. Payment at time of each treatment session.

WHEN WE ARE PARTICIPATING PROVIDERS

1. Patient is responsible for any insurance forms needed
2. Patient is responsible for any referrals (especially if they are needed ongoing i.e.: USHC)
3. Patient is responsible for updating current information and insurance changes
4. Patient is responsible for all Co-Pays & Deductibles

BILLING IF WE ARE NOT PARTICIPATING PROVIDERS:

Options:
1. Our office submits to insurance company as a courtesy. (Copy of bill is given to patient if requested.)
2. Patient receives monthly bill and submits to insurance independently.

PATIENT RESPONSIBILITY

1. Payment in full if a service is not covered.
2. To check with your insurance company: Benefits, Eligibility, Visit Limits, etc.
3. Any Co-Pays.
4. Any Deductibles
5. To inform our office if the patient has received services elsewhere and there is a limited number of visits
6. All costs related to collection and legal fees for procurement of payment will be the direct responsibility of the patient/patient's parents.

It is the subscriber's ultimate responsibility to check your insurance coverage for its guidelines, pre certification requirements and participation of providers. It is the subscriber's ultimate responsibility to obtain a referral (if necessary), know the expiration date of the referral and obtain a new referral when necessary. It is the subscriber's ultimate responsibility to keep our office informed of insurance changes to your policy and keep us updated on your insurance information. IF YOU FAIL TO PERFORM ANY OF YOUR ABOVE RESPONSIBLIITES OR TO KEEP OUR OFFICE INFORMED OF CHANGES TO YOUR INSURANCE; YOU WILL BE BILLED FOR ANY UNPAID CLAIMS. WE WILL BE UNABLE TO BILL MEDICAL ASSITANCE AS YOUR SECONDARY

A $15.00 LATE FEE IS ASSESSED FOR ANY UNPAID PORTION AFTER 30 DAYS & EACH 30 DAYS THEREAFTER

OFFICE POLICY AND INFORMATION

SIBLING POLICY: We ask that the parent supervise all siblings during your child's therapy session. **We would ask that the siblings either stay in the same room with the parent and child receiving therapy or play quietly in the reception area with the toys provided.**

Also, due to the fact that most of the equipment can be dangerous if not supervised, **we ask that only clients, supervised by staff members, use the equipment and apparatus throughout the building.** Your cooperation in this matter is greatly appreciated!

THERAPY SESSIONS: Therapy sessions are usually scheduled for one-hour time periods. **If you do leave the building we ask that you please return at least five minutes prior to the end of your child's session.** If the therapist plans to have your child work longer, they will inform you of the best return time. Please remember the therapist usually has another child scheduled right after yours or may have an appointment away from the building.

If a child arrives late for their appointment, we will try our best to see them for as long as possible but as stated above the therapist has a full schedule either here or away from the building.

CLIENT CANCELLATION POLICY: We realize that in the world of children and busy families, cancellations are sometimes inevitable. With this in mind, we ask that when cancellation of your child's physical, occupational, speech therapy or special instruction appointment is absolutely necessary you give us a call as far in advance as possible. 24-hour notice is preferred but considerations for sudden illness will be made. We are happy to re-schedule missed appointments if possible, but please understand that most of our schedules are quite full and availability of make-up times may be very limited.

Unfortunately, due to our leniency and abuse of "NO-SHOWS" in the past, we find it necessary to hold the following "NO-SHOWS" Policy. The first appointment which is missed without notification of cancellation to our office by the time of the appointment will result in a phone call to remind you of the missed appointment and to re-schedule, if possible. The third missed appointment without notification to our office will result in termination of services for your child. Of course, special emergency circumstances will be considered.

We believe that your commitment to your child's therapy schedule is essential to his or her progress and ultimate development. We thank you in advance for your cooperation in this matter. Helping your child to reach his or her maximum potential is both our privilege and pleasure.

DUE TO CONFIDENTIALITY OF CLIENTS AND OR FILES, WE ASK THAT PARENTS AND SIBLINGS DO NOT GO INTO THE OFFICE AREA OF OUR FACILITY.