

Child's Name: \_\_\_\_\_

Today's Date \_\_\_\_\_

# EXPRESS REGISTRATION

## Personal Info

*Please fill in completely and legibly*

Child's Name: \_\_\_\_\_ M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_ AGE: \_\_\_\_\_

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

Address( list for both parents if not same): \_\_\_\_\_  
\_\_\_\_\_

Mother's Phone#: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

E- mail: \_\_\_\_\_

Father's Phone#: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

E- mail: \_\_\_\_\_

## Referral Info

**\*\*All info is required**

How did you hear about the PEDI Center (if referred by a friend please provide their name and address so we can send a thank you gift \_\_\_\_\_  
\_\_\_\_\_

Primary/ Referring Physician: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Information as written on prescription, include date: \_\_\_\_\_  
\_\_\_\_\_

## Payment Info

**\*\* Circle one**

I am paying by **CASH, CHECK, or CREDIT CARD** and would like to.....

- Pay for 8 sessions up front get 2 additional sessions at no charge (Ask at front desk)
- Pay session to session
- Payment Plan (Fees may apply)

I have **INSURANCE** and would like to.....

- A PEDI Center employee has reviewed my benefits with me and payment terms have been agreed upon. \_\_\_\_\_(initial)
- Have the PEDI Center assist with getting reimbursement from my insurance.
- Get a 20% discount by paying the full amount now and getting reimbursed from my insurance on my own. (Ask at front desk)

## Credit Card on File

*Safe and secure. I understand I will be notified of all charges prior to processing*

Visa \_\_\_ MC \_\_\_ Discover \_\_\_ Card # \_\_\_\_\_ CVV Code \_\_\_\_\_

Name on Card \_\_\_\_\_ Date of Exp \_\_\_\_\_

Child's Name: \_\_\_\_\_

## IMPORTANT COMPANY POLICIES

Please   
initial   
each   
box

**Late Policy "15 minutes"** Being late greater than 15 minutes will require rescheduling your appointment or waiting until the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

**24 Hour Advanced Notice Fee** If you wish to cancel or change an appointment, we require at least **24 hour advanced notice**. Anything less will result in a **\$10 fee** charged to your account. It costs us money to make appointments available to you whether you attend or not (staff wages, rent etc.) We do not make money with this charge it merely deters last minute changes. Advanced notice allows someone else (who needs it) the opportunity to reserve that space. Please be courteous and responsible. Thank you

**All payments are due upon arrival** If you happen to forget your wallet or check book we may still be able to see you but you, will have to fill out an Extension Request. This is a "promise to pay" that carries minimal fee that allows you to keep your appointment.

**No shows are bad** If you fail to show for an appointment without notification you will automatically be removed from the schedule and charge a **\$35 Fail to Show Fee**. You may reschedule appointments again on a 'first come, first serve basis'.

**Cellular phone must be shut OFF or silent** We realize that emergency may arise and you need access to your cell phone, however, please be courteous and set it to silent mode or turn it off during the session. If you must take or make a call we ask you notify the therapist and step outside the building.

**All Children require supervision at all times** All children require adult supervision at all times either with a parent or a therapist. It is NOT appropriate to leave children alone in the waiting area and it is NOT SAFE to allow them to roam unsupervised in the treatment rooms. We encourage parents to be in therapy sessions whenever possible. This includes bringing siblings into the room if they can restrain from disrupting treatment. If clients do not do well with parents in the room or siblings are distracting you will be asked to stay in the waiting area. Your children are responsible for cleaning up after themselves. Please be responsible.

**Financial Hardship** If you are experiencing difficulties and cannot afford the cost of our services we have a 'Financial Hardship Form' you may fill out. If you qualify for financial assistance based on the federal guidelines we may legally assist you by waiving or discounting your (patient responsibility) portion of the bill. Please ask the front desk for assistance.

**Important notice from the federal government** It is unlawful to routinely avoid payment of co-pay, deductible and/ or coinsurance...even if your doctor allows it. Unless you fill out a Financial Hardship Form and qualified based on federal standards you **MUST** pay your responsibility portion as outlined by your insurance. Failure to comply is a violation of the law.

I have read and agree to all the policies.

Sign \_\_\_\_\_ date \_\_\_\_\_

I recognize policies are subject to change at the discretion of the PEDI Center.

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ age \_\_\_\_\_

# CLIENT INFORMATION

## Concerns

Parent's concerns ( try to be specific or provide examples)

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Medical Diagnosis (if applicable)

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## History

Pregnancy & Birth History: \_\_\_\_\_

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Medical History (including surgeries, hospitalizations, significant illnesses or invasive procedure such as BOTOX):---

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Developmental History:

rolling ( back to stomach) _____ months	babbles _____ yes no
sitting (hands free to play) _____ months	1st word _____ @ _____ months
crawling (hands and knees) _____ months	communicates verbally yes no
walking _____ months	speaking in phrases yes no
primary language in the home _____	sensory aversions _____

## Services

**PLEASE PROVIDE NAMES, ADDRESSES & PHONE NUMBERS TO ALL SPECIALISTS WHO TREAT YOUR CHILD.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Other services previously or currently received ( include school therapies)**

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**Daily Routine: (including sleeping schedule and school schedule)** \_\_\_\_\_

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Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ IDC-  
9 \_\_\_\_\_

Play and Education for Development Inc.  
**Assignment of Benefits**

Insurance Policy #: \_\_\_\_\_ Plan Name \_\_\_\_\_  
Employer \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Date of  
Birth \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check  
made out and mailed to:

**PEDI Center for Therapy**  
**15414 N 7th St. Ste 3**  
**Phoenix, AZ 85022**  
**602 476 7519**

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct  
you to make out the check to me and **mail it to the above address** for the professional or  
medical expense benefits allowable, and otherwise payable to me under my current insurance  
policy as payment toward the total charges for the professional services rendered.

**This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have  
agreed to pay, in a current manner, any balance of said professional service charges over and  
above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the  
original.
- I authorize the release of any medical or other information pertinent to my case to  
any insurance company, adjuster, or attorney involved in this case for the purpose of  
processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize PEDI Center to deposit checks made in my name.
- I authorize PEDI Center to complain to the Insurance Commissioner for any reason  
on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by  
insurance.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

# Statement of Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Star Rehab Corp with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Client's Name (print)

\_\_\_\_\_  
Parent/Gaurdian's Signature Date

\_\_\_\_\_  
Authorized Facility Signature Date