



9835 Northcross Center Court  
Suite B  
Huntersville, NC 28078

Phone: 704.896.8688  
ext. 207

Fax 704.896.7975

# Move and Grow! Inc.

## WELCOME TO MOVE & GROW PHYSICAL THERAPY!

We appreciate you giving us the opportunity to be of help to you and your family. The purpose of this document is to provide you the appropriate paperwork necessary to begin your child's treatment.

Attached you will find all of the forms and policies that need to be printed and completed before your arrival so that we can maximize the short amount of time that we have together.

Do not hesitate to contact our office if you have any questions at **(704) 896-8688 x 207**.

Again, thank you for your confidence in **Move & Grow!** and we look forward to assisting you and your family.

Jackie Currie, PT



# Move and Grow! Inc.

## New Patient Information

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Date \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for Visit \_\_\_\_\_

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

Child's Date of Birth \_\_\_\_\_ Child's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Child's Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Mom's Name \_\_\_\_\_

Dad's Name \_\_\_\_\_

With Whom does the Child Reside? \_\_\_\_\_

Mom's Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Wk Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Dad's Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Wk Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mom's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Dad's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mom's Date of Birth \_\_\_\_\_ Dad's Date of Birth \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_



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## INSURANCE INFORMATION

Primary Insured's Name \_\_\_\_\_ ID# \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Insured's Name \_\_\_\_\_ ID# \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

## MEDICAL/DEVELOPMENTAL HISTORY

Most recent eye exam \_\_\_\_\_ Results \_\_\_\_\_

Most recent hearing exam \_\_\_\_\_ Results \_\_\_\_\_

Other recent exams or evaluations (speech, allergist, psychologist, orthotist, orthopedist, etc.)  
\_\_\_\_\_

Any other current therapies \_\_\_\_\_

Previous physical therapy services? \_\_\_\_\_

## BIRTH HISTORY

Full Term? \_\_\_\_\_ If not, number of weeks gestation \_\_\_\_\_

Type of Delivery: Vaginal C-Section

Complications during labor and delivery \_\_\_\_\_

## MEDICAL HISTORY

List any of the following with dates/ages:

Surgeries \_\_\_\_\_

Recurrent Ear Infections \_\_\_\_\_ Tubes? \_\_\_\_\_

Illnesses \_\_\_\_\_ Seizures? \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Allergies \_\_\_\_\_ Medications \_\_\_\_\_

## DEVELOPMENTAL HISTORY

Developmental Milestones: Delayed \_\_\_\_\_ Average \_\_\_\_\_ Advanced \_\_\_\_\_

Struggles/Concerns: \_\_\_\_\_

\_\_\_\_\_

Located at Lake Norman  
Children's Therapy, LLC



# Move and Grow! Inc.

## PARENTAL CONSENT FOR PRIVATE PHYSICAL THERAPY SERVICES

I consent to physical therapy services for my child \_\_\_\_\_. I understand that these services will include a written evaluation, ongoing assessment based on functional outcomes and observed performance, and treatment deemed necessary based on assessment findings.

I agree to pay for services on the date the services are rendered. The cost is \$95 per visit. This is in lieu of seeking third party reimbursement.

I authorize the release of information to outside parties who have a legitimate need for this information. I understand that no information will be released without first explaining to me the nature of the request for the release.

Parent/Guardian Signature \_\_\_\_\_

Date:

## **ASSIGNMENT OF INSURANCE BENEFITS TO THERAPISTS**

I authorize direct payment of medical benefits to the attending therapy group. The benefits referred to herein would be payable to me if I did not make assignment and include major medical insurance. I understand that I am personally responsible to the therapy group for charges not covered or paid by this assignment.

Parent/Guardian Signature \_\_\_\_\_

Date:

## **AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR INSURANCE PURPOSES**

The attending therapy group is authorized to release any medical information required in the administering of applications for financial coverage for services required. The attending therapy group may also send results of evaluations and recommendations to referring physicians and involved agencies for coordination and continuity of care. I have carefully completed this form and to the best of my knowledge it does not contain any false, incomplete or misleading information.

Parent/Guardian Signature \_\_\_\_\_

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## CONSENT TO PARTICIPATE IN TREATMENT IN A NATURAL ENVIRONMENT

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\_\_\_\_\_ has my permission to participate in therapy/activities/  
sessions in natural environment settings at Move & Grow! Inc. I understand that this presumes  
the presences of a wide variety of other people including other children, siblings, parents, co-  
workers, volunteers, students, and other community members. In addition to the natural play  
environments on location; my child may participate in therapy in the home, school, and commu-  
nity to maximize carryover of functional skills.

Parent/Guardian Signature \_\_\_\_\_  
Date: \_\_\_\_\_

## CONSENT TO RELEASE/RECEIVE MEDICAL INFORMATION

I agree to let Move & Grow! Inc. share and receive information from other agencies  
(organizations) about my child so that services ca be coordinated and optimized for my child's  
benefit. The following agencies (organizations) are included in this release:

Pediatrician \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Other \_\_\_\_\_

I understand that this release will be in effect until my child's chart is closed or until this consent  
is amended in writing.

Parent/Guardian Signature: \_\_\_\_\_

Date:

Child's DOB:

Witness Signature: \_\_\_\_\_

Date:

Child's DOB:



# Move and Grow! Inc.

## DISCLOSURE OF FEES

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CPT CODE	SERVICE	FEE:
97001: PT	EVAL	\$225.00
97530:	THERAPEUTIC ACTIVITIES	\$116.00 PER HOUR
97113:	AQUATIC THERAPY	\$129.00 PER HOUR

I have read the above codes and fees and understand the cost of my care with my treating therapist. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I also understand that if a check is returned for insufficient funds, I will be charge a \$25.00 service charge.

I further understand that if my insurance company declines payment, I authorize Move & Grow! to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed. I have read and fully understand the above financial terms and prices.

Parent/Guardian Signature \_\_\_\_\_

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## CANCELLATION POLICY

Move and Grow! Inc. realizes that there are times when families need to cancel therapy appointments due to illness, conflicting appointments, vacations or other family issues. We request that families provide at least 24 hours notice when therapy appointments must be cancelled. This enables the therapist to make the best use of the cancelled time slot to see other children or meet other job responsibilities.

The following procedure explains how cancellations will be handled:

- If a family cancels three appointments with less than 24 hours notice in 90 day period for any reason (including illness) the therapist may reassign that child to another slot. If a family does not show up for an appointment and does not call to cancel that appointment at least 2 times in a 90 day period, the therapist may:

Suspend regularly scheduled services and reassign the child to another slot.

Suspend regularly scheduled services and place the child's name on the waiting list.

Suspend regularly scheduled services and allow the family to call in on a day to day basis for an open appointment slot.

- Children who no show for 2 consecutive appointments will be discharged. A \$25 fee will be assessed for cancellations made with less than 24-hour notice.

Please call the office as soon as you realize that your child will not be able to attend therapy. You may leave a message on voice mail 24 hours a day.

Parent/Guardian Signature \_\_\_\_\_  
Date: \_\_\_\_\_



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## NOTICE OF PRIVACY POLICIES AND PRACTICES

This notice describes how physical therapy and medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully.

### Uses and Disclosures for Treatment, Payment, and Health Care Operations

Move & Grow! Inc. may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

“PHI” refers to information in your child’s health record that could identify him/her.

“Treatment, Payment, and Health Care Operations”

*Treatment* is when we provide, coordinate, or manage your child’s health care and other services related to your child’s health care. An example of treatment would be when your child’s physical therapist consults with another health care provider, such as your child’s family physician or another health care professional.

*Payment* is when we obtain reimbursement for your health care. Examples of payment are when your child’s PHI is disclosed to your health insurer to obtain reimbursement for your child’s health care or to determine eligibility or coverage.

*Health Care Operations* are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

“Use” applies only to activities within the practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies your child.

“Disclosure” applies to activities outside of the practice group, such as releasing, transferring, or providing access to information about you to other parties.

### Uses and Disclosures with Neither Consent or Authorization

Move & Grow! Inc. may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse:** If Move & Grow! Inc. knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, the law requires such knowledge or suspicion to be reported to the North Carolina Department of Children and Families.

**Adult and Domestic Abuse:** If Move & Grow! Inc. knows, or has reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires us to immediately report such knowledge or suspicion to the North Carolina Department of Children and Families.

**Health Oversight:** If a complaint is filed against Move & Grow! Inc. with the North Carolina Department of Children and Families on behalf of the North Carolina Board of Physical Therapy Examiners or any other Board, the Department has the authority to subpoena confidential physical therapy information



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from us relevant to that complaint.

**Judicial or Administrative Proceedings:** If you are involved in court proceeding and a request is made for information about your child's diagnosis or treatment and the records thereof, such information is privileged under state law and will not be released without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform us that you are opposing the subpoena or a court order. The privilege does not apply when your child is being evaluated for a third party or where the evaluation is court ordered. You will be informed if this is that case.

## Patient's Rights and Therapist's Duties

### Patient's Rights:

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about your child. However, Move & Grow! Inc. is not required to agree to a restriction you request.
  - *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, upon your request, I will send your bills to another address.)
  - *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in your child's physical therapy and billing records used to make decisions about you for as long as the PHI is maintained in the record.
  - *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Move & Grow! Inc. may deny your request. At your request, we will discuss with you the details of the amendment process.
  - *Right to Accounting:* You generally have the right to receive an accounting of disclosures of PHI regarding your child. At your request, details of the accounting process will be discussed with you.
- Right to a Paper Copy:* You have the right to a paper copy of this Notice from Move & Grow! Inc. upon request.

### Therapist's Duties:

- The law requires Move & Grow! Inc. to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- Move & Grow! Inc. reserves the right to change the privacy policies and practices described in the Notice. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.

If these policies and procedures are revised, you will be notified in person or by mail.

## Complaints

If you are concerned that your child's privacy rights have been violated, or you disagree with a decision made about access to your child's records, you may contact Move & Grow! Inc. You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services. You will be provided with the appropriate address upon request.

**Effective Date to Privacy Policy:** This notice will go into effect on May 20, 2005



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## NOTICE OF PRIVACY PRACTICES

I respect the confidentiality of your child's health information and will protect this information in a responsible and professional manner. I am required by law to maintain the privacy of your child's health information and to inform you of your right to privacy.

You have the right to ask me to restrict how I use or disclose your information for payment or health care operations.

You have the right to request confidential communications of information.

You have the right to copy and inspect components of your child's information that I obtain. You may be charged a fee for copying and postage.

I have been adequately informed of my right to privacy.

Parent/Guardian Signature \_\_\_\_\_

Date:

-