**Early Intervention Associates LLC**
**Pediatric Physical Therapists**
6208 Montrose Road
Rockville, Maryland 20852
Phone 301 468 9343
Fax 301 230 2127

# INFORMATION SHEET

Child's Name _____ Child's Date of Birth_____

Parent's Names _____

_____

Best phone number to reach you: _____

Email address _____

Address _____

_____

Name of Primary Insurance_____

Policy Holder: _____

Policy Holder's Date of Birth_____

Policy Number_____ Group Number_____

Insurance Address_____

Insurance Phone Number_____

Pediatrician _____

Address _____

Phone number _____

Please list other physicians (orthopedist, physiatrist, neurologist, etc.)

_____

_____

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EARLY INTERVENTION ASSOCIATES, LLC BILLING POLICIES

1. Each family is responsible to check with the front office prior to leaving to assure that insurance and copayments are paid.
2. Copays are due with each visit.
3. An administrative fee of $25.00 will be charged at initial evaluation for each child. We require each family who has been receiving physical therapy services for greater than 6 months to pay a biannual fee of $50.00 for administrative fees in January and again in July of each year.
4. The family is responsible for the physical therapy bill. If a bill is sent to the family, he payment is to be paid within 3 weeks. A 5% interest per month late fee will be incurred for all accounts not paid in full 3 weeks after the family has been billed.
5. Please inform us immediately if your insurance is requesting reports.
6. Your insurance coverage, deductibles and other rules will be confirmed on your first visit. These benefits are not a guarantee of payment per the insurance companies' policies.
7. You will be allowed one missed visit cancelled in less than 24 hours, every 6 months. If you missed an appointment subsequently without notice or within 24 hours, we reserve the right to bill for the session at $70.00. This is a direct bill to the family and will not be billed to your insurance.
8. If an extensive report is needed for collaboration with other professionals, therapy authorization or an appeal, you will be billed directly for the cost of your therapist's time up to one hour at $70.00 per hour. Such reports are not covered by your insurance.
9. If a therapist accompanies you the physician, school meeting, orthotist, or other health professional for collaboration, you will be billed at the home visit rates.
10. If equipment or supplies are purchased by EIA on behalf of your child, we will not bill the insurance. It will be billed to you directly.
11. Families are required to provide a credit card which we will keep on file securely and HIPAA Protected. The credit card will be used to pay any deductibles and copays. Additionally, with your permission, we will use the card to cover supplies which are not covered by your insurance.

Name on the card_____Childs Name_____
Credit Card # _____ Exp Date _____
Card Verification Value (CVV) _____ Card Type __Visa__ Mastercard __AMEX __Discover
Billing Address _____
_____

Signature _____ Date _____

## HIPAA RELEASE

The Notice of Privacy practices (HIPAA) explains how your or your child's health information may be used or disclosed by us. In addition, it explains your or your child's rights with regards to your or your child's protected health information, as well as our legal responsibilities.

I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices on behalf of myself or my child.

Signature _____ Date _____

I give permission to share my child's health information with the following practitioners for the following purposes:

1. To provide, coordinate, and manage health care treatment
2. To communicate to your child's physician
3. To provide documentation to your insurance as requested in seeking payment for physical therapy claims
4. To fulfill legal requests that you have authorized

Pediatrician □ yes □ no
Medical specialist(s) (ie. neurologist, geneticist, developmental pediatrician) □ yes □ no
Other therapist(s) (ie. occupational therapists, speech therapists, etc.) □ yes □ no

Signature _____ Date _____

## EMERGENCY MEDICAL CARE

I permit Early Intervention Associates, LLC to take my child to the nearest emergency department for treatment in an emergency when I cannot be contacted immediately. EIA will contact you as soon as we can

Signature _____ Date _____

## CONSENT TO COMMUNICATE VIA EMAIL

I _____ (parent/guardian's name) as parent/guardian of _____ (child's name) give permission to Early Intervention Associates, LLC to communicate with me using e-mail. I understand that e-mail communications from Early Intervention Associates, LLC are not encrypted and it is possible that the confidentiality of such communications may be breached by a third party. Early Intervention Associates, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of e-mail information sent and received.

Signature _____ Date _____