BIG BLUE CANOPY

PEDIATRIC GYM & THERAPY SERVICES

11230 Cornell Park Drive
Blue Ash, OH 45242
Phone: 513-880-6800
Fax: 513-954-0045

Thank you for choosing Big Blue Canopy for your therapy services. We are looking forward to seeing you and your child.

Our practice philosophy is centered on the belief that each patient is unique and has individual needs and concerns. We are committed to involving you in the course of treatment and will work closely with you to help you understand all aspects of your plan of care and treatment recommendations that may be made.

As a new patient, your initial appointment will include a detailed evaluation by one of our therapists, we will discuss any findings and recommend treatment keeping your family's goals in mind. Please plan to arrive 15 minutes early for your appointment and expect to spend 60 minutes for this visit.

Please find enclosed the new patient paperwork. You may fill this out and bring it to the appointment, along with the insurance card and a previous evaluation.

If you would like to send the paperwork back prior to the appointment our fax number is 513-954-0045 or you can email it to s.prince@bigbluecanopy.com.

We look forward to meeting you at your visit. If there is anything that we can do to enhance your experience in our office or if you have any further questions, please feel free to call our office at 513-880-6800.

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Patient Information

Child's full name: ______________________ Child's preferred name (nickname): ______________________

Date of Birth: ______________________ Age : ________ Sex: ______________

Address: ____

City: ______________ State: ______________________ Zip: ______________

Is the patient a foster child? Yes/ No : ________

Case Worker Name: ______________ Phone: ______________ County: ______________

Additional information regarding care, contact, and restrictions: ______________________

Whom may we thank for referring you to our office?: ______________________

Guardian Information

Guardian Name (1): ______________________________

Address: ____

City: ______________ State: ______________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email: ______________________________

Guardian Name (2): ______________________________

Address: ____

City: ______________ State: ______________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email: ______________________________

Physician Information :

Physician/ Pediatrician(Name and Facility): ____________________

Physician Phone number: ____________________ Physician Fax Number: ____________________

Insurance Information :

Please list all the insurance plans for which the patient is a beneficiary.
If your child is covered by CareSource,Buckeye Community plan, Moline, UNC Community Plan, Paramount, or Medicaid, please list any and all commercial insurance policies that list your child as beneficiary in order to ensure that all claims are processed appropriately.

Primary Insurance:

Policy Holders Name: ____________________ DOB: ____________________

SSN: ____________________ Employer: ____________________

Insurance Company Name & Address:

____

Phone: ____________________ ID#: ____________________ Group: ____________________

Secondary Insurance:

Policy Holders Name: ____________________ DOB: ____________________

SSN: ____________________ Employer: ____________________

Insurance Company Name & Address:

____

Phone: ____________________ ID#: ____________________ Group: ____________________

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DEVELOPMENTAL AND MEDICAL HISTORY

Child's name : ______________________ Date of Birth : ______________

Name of person completing this form : ______________________

Relationship to child : ______________________

Is your child adopted ? Yes No

Birth History

Child was born: full-term or premature;If premature, how many weeks ? ______________

Delivery: vaginal with forceps C-section

Were there any complications ? ______________________

Was your child placed in the Newborn Intensive Care Unit ? ______________ If so, how long ? __________

Please describe any other medical problems or complications at birth.

____

Developmental History

Please indicate at what age your child achieved the following milestones:
*Mark N/A for those which your child has not achieved yet

Rolled over	______	Babbled	______	Sat alone	______
Said first word	______	Crawled	______	Drank from a cup	______
Pulled to stand	______	Used spoon	______	Stood alone	______
Toilet trained	______	Walked alone	______	Dressed self	______

Current limitations : ______________________

Comments:

____

Medical History

Current diagnosis: ____________________

Hospitalizations: No Yes; If yes, please describe

____

Surgeries: No Yes; If yes, please list ____________________

Previous psychological evaluation ? No Yes; If yes, please describe

____

Current physician(s): ____________________ Medications: ____________________

Special equipment your child uses: Splints Braces Adaptive utensils Other ____________________

Any feeding problems or nutritional concerns ?

____

Please check all that apply to your child:

Tracheostomy	Allergies (list below)	Hearing aids	Wears glasses
C-Line	Latex Sensitivity	Hearing difficulty	Vision problem
G-tube	Seizures		

Comments:

____

Educational Information

School/Educational program currently attending: ____________________

Present grade level: ____________________

Special services received in school: OT PT Speech

Does your child receive any of the following?

Special Education Behavior Intervention Other special service

Does your child's teacher have concerns with your child's development in any of the following areas:

Motor skills Social abilities Self-help skills Learning abilities

Comments:

____

Social/Emotional Development

Does your child interact well with others ? Yes No

Does your child have any trouble making friends ? Yes No

Fears, Coping behaviors :

Does your child have difficulty calming himself/herself when upset ? Yes No

Additional comments:

Behavior

Please check any of the following that apply to your child:

Cries often	Dislikes hair brushing	Frequent temper	Tantrums
Dislikes tooth brushing	Anxious	Avoids touch from others	
Trouble following directions	Dislikes playground equipment	Trouble with changes in routine	
Seems to be “on the go” Clumsy	Rocks self	Weak muscles	
Sensitive to light	Picky eater	Sensitive to sound Mouths objects	
Poor attention span			

Other Professionals Working With Child

Optometrist/Ophthalmologist	ENT-Otolaryngologists	Neurologist	Physiatrist
Orthotist/Prosthetist	Orthopedic Physician	Care Coordinator/Service Coordinator	

Other :

Has your child received occupational therapy, physical therapy, or speech therapy before ? Yes No

If yes, please indicate which services and for how long :

Family Goals with Therapy

Child's strengths:

Parent Concerns:

Child’s other interests/hobbies:

Goals for therapy

Thank you for taking the time to fill out this questionnaire.

Signature of Parent/ Legal Guardian: Date

(By typing your name above you agree that your typed signature can be used as your actual signature.)

Relationship to the Patient

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Attendance Policy

Scheduled Appointments

- Please arrive for each appointment 10 min early, giving enough time to check in and begin therapy at the scheduled time.
- We recommend that you be involved in your child's treatment session. If you choose to stay in the waiting area, please be available 15 minutes prior to the session being completed to enable the therapist to discuss your child's progress, plan of care and home exercise recommendations.
- A late fee of $10 may be assessed if you are 10 minutes or more late for your appointment.
- Late arrivals may need to be rescheduled in order to provide optimum care for you and to avoid inconveniencing other patients

Cancellation and Reschedules:

- We realize that your time is valuable and thus have appointed a specific time for you to minimize your waiting. We ask that you show us the same courtesy. If you are unable to keep your appointment, please notify the office at least 24 hours prior to your appointment so that another patient can be scheduled.
- Our staff will ask your availability to reschedule the appointment within the same week.
- Multiple cancels and reschedules require reviewing your families schedule to determine a time better suited to your needs.
- We reserve the right to charge a $35 fee for no-shows and late cancellations.
- More than 2 consecutive cancels (with no reschedules) or no shows will result in removal from schedule.

Snow Emergency Policy:

- Our offices will remain open in the event of Level 1 or Level 2 snow emergencies. However, please exercise caution if you choose to attend your appointments in these conditions. If you choose not to keep your appointment, please call our office to reschedule. We will close our office if it is located in a county with a Level 3 snow emergency. If we are closed due to a Level 3 snow emergency, our office will contact you on our next business day in order to reschedule your appointment.

Contagious Disease Policy

- Children and adults with contagious illnesses must stay home in order to prevent the spread of illness to others. Contagious diseases spread from one person to another. Often, people who spread disease do not look or feel sick. The germs spread by direct contact (touching), by coughing or sneezing, or by germs from the stool (bowel movement) or by blood getting on surfaces. Maintaining health and preventing the spread of contagious diseases are responsibilities shared by parents and our staff. Our interest is in preventing the spread of contagious diseases and therefore we ask parents to reschedule an appointment, rather than bringing a sick child into our office.

Signature of Parent/ Legal Guardian: ______________________________ Date : ________________

(By typing your name above you agree that your typed signature can be used as your actual signature.)

Relationship to the Patient ______________________________

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CHANGES TO INSURANCE POLICY

It is the responsibility of the policy holder to notify Big Blue Canopy,LLC of any insurance policy changes. Not having current insurance information on file may result in denials and the policy holder being invoiced for denied visits.

I have read and understand the above items

Patient Name: ______________________________

Signature of Patient's Guarantor ______________________________ Date ______________

(By typing your name above you agree that your typed signature can be used as your actual signature.)

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Consent for medical care and treatment

PATIENT NAME: ______________________________

My child is being treated at Big Blue Canopy, LLC. for a condition requiring treatment.

I consent to all medical care and tests determined by my therapist that are necessary for my child. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of care. I also understand that if I do not follow my therapist's recommendations as they may relate to my child's health, the therapist and this office will not be responsible for any injuries or damages that are the result of my noncompliance.

Such treatment encompasses procedures and medical treatments as ordered by

____

who is my child's ordering physician.

I authorize Big Blue Canopy, LLC. and their designated representatives' permission to communicate and coordinate my child's care with the following:

Pediatrician: ______________________ Phone: ______________________

Other Physician: ______________________ Phone: ______________________

School System Therapist: ______________________ Phone: ______________________

School System Employee: ______________________ Phone: ______________________

Relative: ______________________ Phone: ______________________

I authorize Big Blue Canopy, LLC. and their designated representatives to communicate with those mentioned above as it relates to my child's care (check all that apply):

Email : Yes No

Text : Yes No

Phone : Yes No

Mail : Yes No

Signature of Patient's Legal Representative ______________________ Date ______________

(By typing your name above you agree that your typed signature can be used as your actual signature.)

Relationship of Legal Representative to Patient ______________________

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FINANCIAL AND INSURANCE POLICY

Billing Service : We will provide one of the following to the parent/guardian/person responsible for payment

- A detailed super bill to present to your insurance company for insurance reimbursement. The Super bill will include the Diagnosis Code, Insurance information, client DOB, CPT codes and descriptors, the amount charged and payments received, and reimbursement recipient

OR

Claims can be submitted to your insurance carrier by Big Blue Canopy,LLC on your behalf.

It is your responsibility to understand your benefits and your expected financial responsibility relating to your contract with your insurance company.

Assignment of Benefits : I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to Big Blue Canopy,LLC. for services provided.

Financial Responsibility : I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance, including any and all products or services rendered to me which are not eligible for payment (non-covered) under health care plan or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). I am also responsible for co-payments, co-insurance and/or deductibles required by my insurance plan and will make payment to Big Blue Canopy, LLC. upon receipt of invoice. Such charges will reflect on the member's Explanation of Benefits (EOB) form provided by their carrier to the member and Big Blue Canopy, LLC.

Signature of Parent/ Legal Guardian : ______________________ Date ____________

(By typing your name above you agree that your typed signature can be used as your actual signature.)

Relationship to the Patient ______________________

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HIPAA Release of Information AUTHORIZATION FORM

I hereby authorize Big Blue Canopy, LLC. and its affiliates, its employees and agents , the ability to send me electronic communication containing my personal health information maintained (such as information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, Member ID number, payment arrangements and balance information) except the following information about me:

____

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping me to resolve claims, or health benefit coverage issues, and the purpose of communication regarding plan of care.
I also allow the Big Blue Canopy, LLC. staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of the child.

I understand that the electronic communication will be sent via an unsecure/unencrypted email network.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date listed below for one year.

I understand that I have a right to revoke this authorization by providing written notice to Big Blue Canopy, LLC. However, this authorization may not be revoked if Big Blue Canopy, LLC, its employees or agents have taken action on this authorization prior to receiving my written notice.

I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Signature of Parent/ Legal Guardian: ______________________________ Date ______________

(By typing your name above you agree that your typed signature can be used as your actual signature.)

Relationship to the Patient ______________________________

Notice of Privacy Practices and Confidentiality Agreement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Use and Disclosure Information:
We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.
Coordination of Care: PHI will be shared with other health care professionals in order to effectively manage care of the patient. This may include doctors, nurses, technicians and other health care providers.
Payment: Insurance companies require PHI in order to process payments on your behalf for services rendered. Your insurance company may request a review of your medical record to determine medical necessity.
Appointments: We may use or disclose your health information to provide you with appointment reminders (email, voicemail, postcards or letters)
Check -In: Your child's name may be called when checking in at our window.
Schools and Agencies: We may provide information requested for IEP's and evaluations with other professionals. We may disclose your child's information to doctors and other health professionals in regards to your child's care with us.
Oher permitted Uses and Disclosures: We may share information with other Public health authorities charges with preventing or controlling disease, injury or disability. We will notify appropriate persons if we suspect child abuse or neglect.
Uses and Disclosures Required by Law: The federal health information privacy regulations either permit or require us to use or disclose the patient's PHI in the following ways: we may share some of the patient's PHI with a family member or friend involved in the care if you do not object. We may use your PHI in an emergency situation when the patient may not be able to express themselves. We may use your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. Authorization by the patient or legal guardian is required before your PHI may be used or disclosed by us for other purposes.

Your Privacy Rights Restrictions:
You have the right to request restrictions on how the patient's PHI is used, however we are not required to agree with the request. If we do agree, we must abide by the request.
Confidential Communications: The patient and/or legal guardian have the right to request confidential communication from us at a location of your choosing. This request must be in writing.
Access to PHI: The patient and/or legal guardian have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of mailing.
Amendments: You have the right to request an amendment be made to our PHI, if you disagree with what it says. This request must be made in writing. If we disagree with your, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. WE may not amend parts of your medical record that we did not create.
Complaints: If you feel that your privacy rights have been violated, the patient and/or guardian has the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. Complaints should be submitted to the HIPAA Compliance Officer. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy:
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Signature of Parent/Legal Guardian: ____________________________ Date: _________________

(By typing your name above, you agree that your typed signature can be used as your actual signature)

Printed name of Parent/Legal Guardian: ____________________________________

Relationship to the Patient: ______________________________________

Big Blue Canopy Pediatric Gym and Therapy Services
11230 Cornell park Drive
Blue Ash, OH 45242
(513) 880 6800

Release of Information Form

Childs name: ___________________________________ Date of Birth: _____________________

This form allows Big Blue Canopy LLC to send and receive Evaluations, reports, and other requested information, including sending claims to your insurance provider. If we do not have this form filled out we will to be able to provide this service on your patients behalf.

I authorize and request my child's ordering physician and Big Blue Canopy LLC to release all information concerning my child's case history, care and treatment while being cared for by Big Blue Canopy, LLC. These records, or review of same can be released to representatives of my insurance company or any other third-party source of payment responsible for my bill.

I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Big Blue Canopy, LLC to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

(OPTIONAL)

I give permission to Big Blue Canopy, LLC to photograph and/ or videotape my child, and use said photos/videos for promotional or teaching purposes.

Agree

Disagree

Signature of Parent/Legal Guardian: ____________________________ Date: ____________________
(By typing your name above, you agree that your typed signature can be used as your actual signature)

Printed name of Parent/Legal Guardian: ____

Relationship to the Patient: ______________________________________