First Step
Pediatric Therapy

PELVIC HEALTH INTAKE & CONSENT

Patient and family contact information:

Patient Name: _____ Sex (circle one): M F
Date of Birth: _____

Parent/Guardian 1
Name: _____
Address: _____
City: _____ State: _____
ZIP: _____
Phone: (_____)_____
Email: _____
Occupation: _____

Parent/Guardian 2
Name: _____
Address: _____
City: _____ State: _____
ZIP: _____
Phone: (_____)_____
Email: _____
Occupation: _____

Medical:
Pediatrician/primary care physician: _____ Phone: (_____)_____
Referring physician (if different from above): _____Phone: (_____)_____
Diagnosis (if known):_____

Emergency contact:
Name: _____ Phone: (_____)_____
Relation to your child: _____

Insurance:
Primary Insurance: _____ Subscriber name: _____
Relationship to Subscriber: _____ Subscriber DOB: _____
Group number: _____ ID number: _____

Secondary Insurance: _____ Subscriber name: _____
Relationship to Subscriber: _____ Subscriber DOB: _____
Group number: _____ ID number: _____

How did you find us?
_____ Google
_____ Facebook or Instagram
_____ Friend/word of mouth
_____ Physician recommendation
_____ Other: _____

First Step
Pediatric Therapy

Informed Consent for Treatment:
The term “informed consent” means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my child’s condition. I also acknowledge and understand that my child has been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions. I understand that to evaluate my child’s condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region. Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Signature: _____ Date: _____

Potential risks:
My child may experience an increase in their current level of pain or discomfort if any, or an aggravation of their existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my child’s physical therapist.

Signature: _____ Date: _____

Potential benefit:
My child may experience an improvement in their symptoms and an increase in their ability to perform daily activities. They may experience increased strength, awareness, flexibility and endurance in their movements. They may experience decreased pain and discomfort. They should gain a greater knowledge about managing their condition and the resources available to them.

Signature: _____ Date: _____

Alternatives:
If I do not wish for my child to participate in the therapy program, I will discuss their medical, surgical or pharmacological alternatives with their physician or primary care provider.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my child's condition. I understand that my child's therapist will share with me her opinions regarding potential results of treatment for my child's condition and will discuss all treatment options with me before I consent to treatment. I have informed my child's therapist of any condition that would limit my child's ability to have an evaluation or to be treated. I hereby request and consent to the evaluation of my child and treatment to be provided by the therapists and therapy assistants and technicians of First Step Pediatric Therapy

Signature: _____ Date: _____

Notice of Privacy Practices:
While providing services to our patients, we create, receive and store personal health information. We use and disclose your health information for treatment, payment, or health care operations. The Notice of Privacy Practices describes these uses and disclosures in detail. I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices from First Step Pediatric Therapy.
Please see full Notice of Privacy Practices in a separate from sent with paperwork

Signature: _____ Date: _____

Consent for Electronic Communication:
First Step Pediatric Therapy utilizes email and/or text communications, which are non-encrypted. I understand that there are risks to sending and receiving treatment information, scheduling reminders and other matters related to First Step Pediatric Therapy using non-encrypted methods. By signing below I consent to non-encrypted email communication.

Signature: _____ Date: _____

Financial Disclaimer/Liability and Billing:
While we attempt to verify your insurance plan for services prior to your appointment as a courtesy, it is the responsibility of the parent/guardian to verify insurance eligibility and benefits, and facilitate referrals & prior authorization before the patient's appointment.

First Step
Pediatric Therapy

All balances not paid within 30 days will incur a late charge of $10 per month. Balances not paid within 120 days may be forwarded to a collection agency and incur a $50 processing fee. There will be a $25 service charge for any returned checks. **Patients with a balance over $500 will be required to make a payment towards the balance, or set up a payment plan before continuing therapy.** I understand and acknowledge First Step Pediatric Therapy's financial policy and authorize First Step Pediatric Therapy to release any information necessary for insurance processing and authorize my insurance to pay First Step Pediatric Therapy directly.

Signature: _____ Date: _____

Insurance Benefits/Prior Authorization:
Your insurance carrier will determine final benefits after claims are processed. You can verify your insurance benefits prior to therapy by accessing your insurance's online portal, or by calling your insurance company. We ask that you please notify First Step Pediatric Therapy of any changes to your child's insurance carrier or coverage immediately while receiving services.

I understand that I am responsible for determining whether prior authorization is necessary and for submitting the request accordingly. I understand that I am responsible for all balances after insurance processing. I understand that First Step Pediatric Therapy is not required to verify my insurance prior to providing therapy services, and that it is my responsibility to provide up to date and accurate insurance information. I understand I am responsible for payment of any unpaid claims due to failure of notifying First Step Pediatric Therapy of insurance changes in a timely manner.

Signature: _____ Date: _____

Monthly Invoices:
Invoices are sent out via email on the 1st of the month (or the following business day, if the first falls on a weekend or holiday). Please indicate below if you would also like invoices mailed after they are sent via email:

- ☐ No, email is fine
- ☐ Yes, please also send my invoice in the mail

First Step
Pediatric Therapy

CREDIT CARD AUTHORIZATION FORM

(Credit / Debit / HSA card). **All information will remain confidential in our secure EMR system.**

First Step Pediatric Therapy requires that all patients have a credit card on file with us. Your card will be charged as per your authorization below. If you would also like to give us HSA card information for convenience to pay towards co-pays, deductibles, and co-insurance, and eligible private therapy related costs, you may do so below. **We are unable to bill other fees to an HSA card, so it's necessary to have both types of cards on file, or solely your credit/debit card.**

Patient Name: _____ Patient DOB: _____

Credit/Debit (REQUIRED FOR ALL)

Cardholder Name: _____

Billing Address:_____

Card Number: _____ Expiration Date: _____

Card Identification Number / CVV (last 3 digits located on the back of the credit card): _____

☐ I authorize First Step Pediatric Therapy to charge my credit card herein, month on the 1st of each month (or first business day of the month) to pay for the balance in full for therapy services rendered to my child including co-pay, co-insurance, deductible, or private pay charge for services, if any, and other fees if proper cancelation procedures are not followed as per the signed cancelation policy.

☐ I do not authorize First Step Pediatric Therapy to charge my credit card automatically. I prefer to make payments myself in person, via phone call, or through the patient portal. I am aware of the $10 late fee if I do not pay my balance within 30 days of the invoice date. Late fee is assessed for every 30 days the balance is not paid.

First Step
Pediatric Therapy

HSA CARD. (A credit/debit card must be added when adding an HSA)

HSA Cardholder Name: _____

Billing Address:_____

HSA Card Number: _____ Expiration Date: _____

Card Identification Number / CVV (last 3 digits located on the back of the credit card): _____

☐ I authorize First Step Pediatric Therapy to charge my HSA card herein, month on the 1st of each month (or first business day of the month) to pay for the balance in full for therapy services rendered to my child including co-pay, co-insurance, deductible, or private pay charge for services, if any, and other fees if proper cancelation procedures are not followed as per the signed cancelation policy.

☐ I do not authorize First Step Pediatric Therapy to charge my HSA card automatically. I prefer to make payments myself in person, via phone call, or through the patient portal. I am aware of the $10 late fee if I do not pay my balance within 30 days of the invoice date. Late fee is assessed for every 30 days the balance is not paid.

Please read over and sign below:

Patients with a balance over $500 will be required to make a payment towards the balance, or set up a payment plan before continuing therapy. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement. Receipts will be sent via email after your card has been charged.

I understand that the above authorization will remain in effect until the designated expiration date or until I cancel it in writing, whichever comes first, and I agree to notify the business of any changes in my account information. Termination of this authorization at least 15 days prior to the next billing date is required in writing. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form. I understand all of the terms and conditions listed on this form.

Card Holder Signature: _____ Date: _____

First Step
Pediatric Therapy

Cancellation Policy:

As a courtesy to our staff, we ask that you please read and adhere to our no show, late cancel, and late policies. These fees are an out-of-pocket expense and cannot be billed to insurance:

- In the absence of an illness, family emergency, or inclement weather, canceling or rescheduling an appointment must be made at least 24 hours prior to the start of your child's appointment. Patients will be billed a $40 late cancellation fee if cancellation is made less than 24 hours in advance.
- Patients who miss a scheduled appointment **without providing the office advance notice** will be billed a "No Show" fee of $75.
- **Patients who are more than >10 minutes late** to a scheduled appointment without advance notice will be billed a $20 late fee.
- Patients who "no show" to three appointments in a 6 month period will be taken off of the therapist's ongoing schedule and must call weekly to schedule an appointment.

I acknowledge that I have read, understand, and agree to the policies above, and that I may ask questions about these policies at any point during my child's care.

Signature: _____ Date: _____

Sick Policy:

The safety and health of our children and staff is our priority, as many of our patients are very young and/or medically fragile.

If you, your child, or a family member in your household are experiencing any of the following symptoms, please call our office to cancel your appointment out of caution and courtesy to our staff and fellow patients. We can change your in-clinic visit to a virtual visit or reschedule your visit to a later date.

- Fever or chills in the past 24 hours
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

If you have tested positive for COVID-19, we ask that:

- You may return after 5 days if symptoms are no longer present or have significantly improved, or after receiving a negative COVID-19 test.

I acknowledge that I have read and understand the policies above, and that I may ask questions about these policies at any point during my child's care.

Signature: _____ Date: _____

Inclement Weather Policy:

Please see comprehensive Inclement Weather Policy on our website, or you can request a copy

To ensure the safety of patients and staff during adverse weather conditions, we have created a policy that can be referenced during extreme weather conditions. The following will only apply to in-clinic appointments, not aquatic therapy appointments.

When inclement weather conditions are anticipated or occur, patients scheduled for in-clinic appointments will be switched to a telehealth appointment. Families will be expected to attend their scheduled telehealth appointment in the event of inclement weather. Families are responsible for contacting First Step Pediatric Therapy via phone call or email if they do not have access to a camera, wifi connection, or hotspot.

By signing below, I acknowledge that I have read, understand, and agree to the policies above, and will contact First Step Pediatric Therapy and that I may ask questions about these policies at any time.

Signature: _____ Date: _____