Great Start
Therapy Associates, LLC

295 Buck Road
Suite 203 Holland PA 18966
Ph (215) 485-5018 F (215) 485-5038

GREAT START THERAPY ASSOCIATES, LLC
ENROLLMENT PACKET

PATIENT INFORMATION: DEMOGRAPHICS

PATIENT NAME:_____ DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER:_____

ADDRESS:_____

PHONE NUMBER:_____PARENT EMAIL:_____

GUARDIAN'S NAME (POLICY HOLDER):_____

DATE OF BIRTH:_____

ADDRESS IF DIFFERENT THAN PATIENT:_____

PRIMARY PHYSICIAN (REFERRING DOCTOR)

DOCTOR'S NAME:_____

PRACTICE NAME:_____

TELEPHONE NUMBER:_____

ADDRESS:_____

INSURANCE INFORMATION:

NAME OF INSURANCE:_____

POLICY NUMBER:_____

GROUP NUMBER:_____

SECONDARY INSURANCE (IF APPLICABLE)

NAME OF INSURANCE:_____

POLICY NUMBER:_____

GROUP NUMBER:_____

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NAMES OF OTHER PHYSCIANS, THERAPISTS, OR SPECIALISTS INVOLVED IN PATIENT'S CARE

NAME	AREA OF SPECIALTY	PHONE NUMBER OR EMAIL

PLEASE LIST ALL MEDICAL DIAGNOSES: _____

_____

PLEASE LIST ALL MEDICATIONS: _____

_____

PLEASE LIST ANY ALLERGIES (i.e. food, animal, seasonal, medications etc):

_____

_____

PLEASE INDICATE ANY DIETERY NEEDS OR FOOD RESTRICTIONS:

_____

PLEASE LIST ANY PREVIOUS HOSPITALIZATIONS, ILLNESSES, SURGERIES, AND PROCEDURES SINCE BIRTH:

_____

_____

_____

HAS THE PATIENT EVER RECEIVED ANY THERAPY PRIOR TO THIS EVALUATION? IF YES, PLEASE INDICATE WHICH THERAPY, WHERE IT WAS IMPLEMENTED (INCLUDING PRIOR EVALUATIONS) AND DATE OF TREATMENT:

SPEECH THERAPY:_____
OCCUPATIONAL THERAPY:_____
PHYSICAL THERAPY:_____
ABA THERAPY:_____

EMERGENCY CONTACT INFORMATION:

NAME:_____RELATIONSHIP TO PATIENT:_____
CONTACT NUMBER:_____

NAME:_____RELATIONSHIP TO PATIENT:_____
CONTACT NUMBER:_____

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- **I hereby give consent for _____to have a snack and/or beverage while in treatment session at GREAT START THERAPY Circle: YES NO**
- **I hereby give consent for GREAT START THERAPY to use the patient's photo on social media, advertisements, promotional pamphlets, website or other interoffice posters Circle: YES NO**
- **I hereby give consent for GREAT START THERAPY to provide evaluation information, treatment plans, and/or progress to be shared with the patient's referring doctor or pediatrician**
- **I authorize any medical or necessary information to process insurance claims**
- **I have received a copy of the PRIVATE PAY POLICY. I understand that I am responsible for paying all therapy fees if insurance denials occur or are not deemed necessary by my insurance company.**
- **I agree to pay copayments, coinsurance, or session fees AT THE TIME OF SERVICE**
- **I authorize receipt of GREAT START THERAPY'S "PRIVACY PRACTICES"**
- **Any balance sent to COLLECTIONS will be charged the maximum interest rate PA allows**
- **I understand and agree to the cancellation policy.**
- **I consent to teletherapy sessions if arranged with my therapist**

Patient or Guardian name (PRINTED):_____

Signature:_____

Date:_____

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CONSENT TO COMMUNICATE

DATE:_____

I,_____, parent of _____,give permission for the therapists at GREAT START THERAPY to share and/or discuss pertinent information regarding the patient's treatment and/or progress with the following THERAPISTS, EDUCATORS, AND PHYSCIANS:

NAME:_____

TITLE:_____

PHONE NUMBER:_____

EMAIL ADDRESS:_____

GUARDIAN PRINTED NAME:_____

GUARDIAN SIGNATURE:_____ DATE:_____

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NOTICE OF PRIVACY PRACTICES

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

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. **The right to inspect and copy your information (copying fees apply)**
2. **The right to request corrections to your information**
3. **The right to request that your information be restricted**
4. **The right to request confidential communications**
5. **The right to report of disclosures of your information**
6. **The right to a paper copy of this Notice**

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will maintain and keep your information private.

If you have any questions about this Notice, the name and phone number of our contact person is listed below:

Effective Date: January 1, 2021
Contact person: Melanie Krevitz Bellissima, OWNER/SLP
Phone number: (215)485-5018

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of GREAT START THERAPY'S "NOTICE OF PRIVACY PRACTICES". I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NPP should it be amended, modified, or changed in any way."

Patient or Guardian Name (please print):_____

Patient or Guardian Signature:_____DATE:_____

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POLICY CHANGES EFFECTIVE 2021

As of January 1, 2021, the **cancellation and no show fee** will be $35.
This fee will be charged for IN OFFICE and VIRTUAL sessions.

CANCELLATIONS

A cancellation fee will be applied if a session is cancelled after 9am of the scheduled day. THREE cancellations per quarter are "allowed". Your standard appointment time will be revoked at the 4th cancellation and appointments will be booked based on therapist availability.

We understand emergencies happen. Please be courteous and call or text us right away. The $35 cancellation fee will be WAIVED if the session is rescheduled (virtually or in person) within 7 business days.

SICK POLICY: IF YOU ANSWER *YES* TO ANY OF THE BELOW, PLEASE CANCEL FOR EVERYONES' SAFETY

- Fever in the last 48 hours
- Unidentified rash or open sores
- Harsh cough with or without yellow/green nasal discharge
- Abnormal lethargic behavior
- Diarrhea or loose stools in the last 24 hours
- Vomiting within the last 48 hours
- Lice, pink eye (untreated)
- Your child did not attend school due to not feeling well

NO SHOWS

If you have a scheduled session and do not attend you will incur the $35 no show fee. Although you are welcome to reschedule this session this fee will not be waived and is due at the time of your next scheduled appointment

Our time is very important, as is yours. If a therapist has to cancel they will let you know in a timely manner and offer a makeup session if wanted. We have many clients that have to be seen, and schedules are very tight. Our therapists are working overtime to accommodate schedules during this crazy time. Please be respectful of our time, so we can be respectful of yours.

- **COVID-19**

If you have to cancel due to reasons regarding COVID-19 please do so as soon as possible and you will NOT incur a cancellation fee. Please reschedule your appointment after receiving negative test results and/or quarantine. Refer to office COVID-19 policy for further questions.

COPAYMENTS

As of January 1, 2021, COPAYMENTS/DEDUCTIBLE PAYMENTS/COINSURANCE PAYMENTS MUST be paid AT THE TIME OF SERVICE.
If you are paying via Venmo, the payment MUST be in by 10pm the day you receive the invoice. If payment is not received by 10pm, your next session will be cancelled until payment is received.

Guardian Name (please print):_____

Signature:_____ Date:_____

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CONSENT TO RECEIVE COMMUNICATION FROM GREAT START THERAPY

I consent to receive calls, texts, and/or emails from GREAT START THERAPY ASSOCIATES, regarding my protected healthcare and other services at the phone number(s) and emails listed below.

I understand my standard data rates apply and that such calls or communication may be generated by an automated dialing system.

Please list the best number(s) AND email addresses to be reached via phone call, text, or email. Please include BOTH parent numbers and emails if not in the same home:

Guardian Name:_____

Number: _____ Email:_____

Guardian Name:_____

Number: _____ Email:_____

Signature:_____Date:_____

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MEDICARE AND INSURANCE CONSENT FORM

I, _____, hereby authorize GREAT START THERAPY ASSOCIATES, LLC, to apply for benefits on my behalf for covered services rendered. I hereby authorize payment of all medical insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to GREAT START THERAPY ASSOCIATES, LLC for services rendered. I further authorize the release of any information needed for processing my insurance. I certify that the information I report with regard to my insurance is correct.

I understand that I am responsible for coinsurance and services not covered by my insurance company. I understand that all copayments will be collected at time of service. For your convenience, we accept cash, check, credit card (fees applied), and PayPal.

Financial Agreement:

I understand that GREAT START THERAPY ASSOCIATES, LLC will verify all information with my health insurance carrier to the BEST OF THEIR ABILITY, but it is MY responsibility to check with my insurance company concerning copayments, deductibles, services, and exclusions. GREAT START THERAPY does NOT guarantee that an insurance company will pay for your care, even when it is preauthorized and verified. GREAT START THERAPY will submit bills to your insurance carrier. We STRONGLY urge you to contact your insurance company to verify your benefits as sometimes incorrect information is provided to us.

I understand that I am FINANCIALLY responsible for any non-covered services and/or any remaining balance. I understand that if I terminate my care and treatment, my balance will be immediately due and payable. I understand I am financially responsible for checks that do not clear and may be charged a bounce fee. Payment plans are at the sole discretion of GREAT START THERAPY and prior arrangements must be made before services are rendered. Patients who are uninsured or whose insurance does not cover speech or occupational therapy due to high deductibles or other limitations are Personally responsible for payment. Payments MUST be paid at the time of service. Copayment and coinsurance are due at the time of service and cannot be waived. Any problems with balances must be address prior to your visit.

TELETHERAPY: I understand that any therapy sessions denied by my insurance due to my insurance carrier not covering telehealth therapy will be my full responsibility. I understand it is my obligation to verify coverage of telehealth with my insurance company prior to therapy.

If for ANY reason a service is not authorized or is denied, I assume full responsibility for any and all charges, including co-payments and deductibles. I agree to pay the bill in full upon being received. There is a $15 per month fee for personal balances after insurance coverage is determined, unless payment arrangements have been made in advance of therapy care.

(x) Patient/Parent/Guardian Signature:_____

Date:_____