Pediatric Boulevard, PLLC

● Physical: 2814 Gray Fox Road, Indian Trail, NC 28079 ● Correspondence: 2814 Gray Fox Road, Monroe, NC 28110
● Business: 704-821-0568 ● Fax: 704-821-0570 ● Email: info@pediatricboulevard.com ● Website: www.pediatricboulevard.com

2017 ANNUAL INTAKE FORMS
PATIENT INFORMATION AND HISTORY

I. IDENTIFYING INFORMATION

Child's Name: _____ **Gender:** _____
(First) (Middle) (Last)
DOB: _____ **SS#:** _____

Address: _____
(Street/Apt #) (City, State & Zip Code)
Primary Guardian's Name: _____

Primary Home Phone: _____ **Cell/Work Phone**: _____

Primary Email Address: _____

Primary Care Doctor/Name of Practice: _____

Primary Care Phone: _____ **Address:** _____

Primary Insurance/Medicaid: _____
Name of Insured: _____ Relationship to Child: _____
ID or Medicaid #: _____ Group #: _____
Address of Insured: _____ Phone: _____
Are Therapy Services covered under your current plan? (Circle) YES NO UNSURE
If NO, You agree to pay for services in full at the time of the visit and will be reimbursed if payment is received by Pediatric Boulevard from your insurance provider.

Secondary Insurance/Medicaid: _____
Name of Insured: _____ Relationship to Child: _____
ID or Medicaid #: _____ Group #: _____
Address of Insured: _____ Phone: _____
Are Therapy Services covered under your current plan? (Circle) YES NO UNSURE

- Is your child currently receiving therapy outside of Pediatric Boulevard (i.e., **school**, hospital)? (Circle) YES NO

If **yes**, what types of therapy? _____

- If you answered **YES** to the questions above**, please provide name and address of provider/school**:

(Name) _____ (Address) _____
Does Pediatric Boulevard have a copy of the current: IEP, IFSP, or care plan from the other agency? (Circle) YES NO

***** If you answered NO, then services will be on hold until the documentation is received. *****
Pediatric Boulevard requires a copy of all other treatment plans from other agencies prior to initiating therapy services.
*** If the child is a Medicaid recipient it is required by the state of North Carolina to provide the documentation.**
*** In addition, Medicaid will not allow both agencies to perform therapy services on the same day.**

Are there any other changes that we should be aware of? (ex., new medication, new diagnosis, etc):

_____
_____
_____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Child's Name:_____DOB: _____

I,_____, hereby authorize Pediatric Boulevard, PLLC to release to:

- Physician (name)_____
- School System (name)_____
- Social Security Administration
- Medicaid
- Family Member (ex., mother and name) please specify:_____,
- Family Member (ex., mother and name) please specify:_____,
- Family Member (ex., mother and name) please specify:_____,
- Additional:_____

INFORMATION TO BE RELEASED (please provide a specific description of the information to be released):

_____

_____

_____

Note: By signing this authorization, you acknowledge that it extends to all or any part of the records designated above, which may include psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you.

PURPOSE OF DISCLOSURE:

□ Legal
□ Provider request
□ Insurance
□ Personal use
□ Changing providers
□ Other: _____

I understand that this authorization will expire on (please provide date or specify "no expiration"). If no date is provided, this authorization will expire one (1) year following the date of signature:

_____

I authorize Pediatric Boulevard, PLLC to release information as listed above:

_____	_____	_____	_____
Signature	Printed Name	Relationship to Patient	Date

The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at a later date if the information has not already been disclosed. We will not condition treatment or payment on your providing this authorization, except in the specific circumstances allowed by the HIPAA Privacy Rule. We cannot protect against the possibility that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by law.

******Reasonable copy fees may apply******

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PEDIATRIC BOULEVARD'S ANNUAL CONSENT RENEWAL – Please initial each box	Initials	Date
Consent for Evaluation and treatment:		
• Consent is given to Pediatric Boulevard, PLLC, to provide Consultation, Evaluation and Treatment.		
• I understand I can revoke this consent at any time if I am not satisfied with the services Pediatric Boulevard provides.		
• This consent is effective one year from the date of initials on Pediatric Boulevard's Annual Consent Renewal form. I understand that I can seek alternative methods of therapy if I am not satisfied with the services that Pediatric Boulevard offers.		
Authorization to Release Health Information:		
• I signed and returned Pediatric Boulevard's Authorization to Release Health Information (page 2).		
• By signing this authorization, I acknowledge that it extends to all or any part of the records designated on page 2, which may include psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you.		
• I understand that Pediatric Boulevard will not release ANY health information to agencies or authorized persons who are NOT listed on our annual intake forms without prior consent of legal guardian.		
Assumption of Risk, Release and Indemnity Agreement:		
• I have read this Agreement, I understand its contents and I sign it voluntarily. **I intend by this Agreement to assume all hazards and risks, waive all rights to sue and release all liabilities and claims, and indemnify Pediatric Boulevard for any claims** arising from my (and/or my child's) participation in the Activity.		
• I understand that this Agreement has **no expiration date** and remains in effect at all times that I am (and/or my child is) participating in the Activity and will be binding on me (and/or my child), my (and/or my child's) family members, heirs, assigns, executors, representatives, and estate.		
Consent for Photography/Video Clips:		
• I give my consent for Pediatric Boulevard to take pictures/video clips of my child for viewing in our lobby/clinic.		
• I give my consent for Pediatric Boulevard to take pictures/video clips of my child for viewing on Pediatric Boulevard's website and/or Facebook page.		
• I understand I can revoke this consent at any time providing written notice.		
• I understand that this consent expires in 5 years, unless specified by guardian.		
• I understand that Pediatric Boulevard does not allow videotaping of my child's session due to HIPPA's regulations and I may ask my therapist to video tape portions of my child's session.		
Email & Text Message Authorization:		
• I received, read and consent to abide by Pediatric Boulevard's Email and Text Message policy.		
• I have elected to communicate with Pediatric Boulevard, PLLC staff by email and/or text messaging. I understand the risk of communicating through these methods, in particular the privacy risks explained in this form. Staff is not responsible for messages that are delayed or not received. Email or text messaging is not a substitute for care and is used primarily for convenience		
Financial Consent:		
• I received, read and consent to abide by Pediatric Boulevard's Financial Policy.		
• I hereby authorize Pediatric Boulevard, PLLC to furnish my insurance carrier any information acquired in the course of my evaluation and treatment necessary to complete my insurance claims. I also authorize my insurance company to reimburse Pediatric Boulevard, PLLC directly for all covered services rendered.		
• If services are not covered by my Insurance Company, I agree to pay for services in full at the time of the visit and will be reimbursed if payment is received by Pediatric Boulevard from my insurance provider.		
Sick Policy:		
• I have received, read and consent to abide by Pediatric Boulevard's Sick Policy.		
Discharge Policy:		
• I have received, read and consent to abide by Pediatric Boulevard's Discharge Policy.		
Notice of Privacy Practice:		
• I have read this Agreement and I understand its contents and how medical information about me may be used and disclosed. I also understand how to I can get access to my medical information.		

PATIENT'S RIGHTS AND CONSENTS: I have received and read Pediatric Boulevard's Annual Intake Forms. I hereby verify the initials above provide my consent for each section that is detailed on pages 1 through 8 on Pediatric Boulevard's Annual Intake Forms.

Signature: _____ **Printed Name:** _____

Relationship to Patient: _____ **Date:** _____

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Please RETURN pages 1-4 to Pediatric Boulevard

Clients KEEP pages 5-8 for your records

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Pediatric Boulevard will only release health information to Authorized agencies and persons noted on Pediatric Boulevard's Annual Consent form. Pediatric Boulevard will not release ANY health information to agencies or authorized persons NOT listed on our annual intake forms without prior consent of legal guardian. Authorized Health information includes, but is not limited to: Psychological testing, Speech therapy records, Occupational therapy records, Physical therapy records, HIV/AIDS/Substance Abuse records, Medical records, etc.

ASSUMPTION OF RISK, RELEASE AND INDEMNITY AGREEMENT

Pediatric Boulevard, PLLC, its trustees, employees, instructors, volunteers, agents, sponsors, and lessors (cumulatively, "Pediatric Boulevard") offers services and activities in and around, and use of, clinical fitness equipment and a swimming pool (the "Activity"). In consideration of Pediatric Boulevard allowing me (and/or my child) to participate in the Activity, I agree to the following:

Assumption of Risk: I understand that physical exercise, swimming, and other activities involving the pool and clinical equipment may cause personal injury, including but not limited to cardiovascular stress and death, as well as harm to personal property. I understand that participation in the Activity involves inherent risk, including unforeseen risks and risks imposed by other participants, and that participation is wholly voluntary. I acknowledge that I am solely responsible for determining and ensuring my (and/or my child's) physical, mental and emotional suitability to participate in the Activity. I (and on behalf of my child) assume all risks and accept responsibility for any property damage and loss, and for any personal injury, illness, disability, emotional distress, and death that I (and/or my child) may suffer as a result of participation in the Activity, whether described above or not.

Waiver and Release: I (and on behalf of my child) agree to forever release and discharge Pediatric Boulevard from any and all liability or claims I (and/or my child) may have for any property damage and loss, personal injury, emotional distress, illness, disability, and death, related to or arising from my (and/or my child's) participation in the Activity. This release is for any kind of claim, including breach of contract, fraud, or any other type of suit, and includes losses alleged to be caused by the negligence of Pediatric Boulevard to the fullest extent permitted by law, but does not include losses alleged to be caused by gross negligence.

Indemnity: I (and on behalf of my child) agree to defend, indemnify (meaning to pay or reimburse any amount required to be paid, including attorneys' fees) and hold Pediatric Boulevard harmless from all claims, causes of action, liability, losses, or damages for any property damage, property loss or theft, personal injury, disability, death or other loss brought by or on behalf of me, my child, a family member, my (and/or my child's) estate, another participant or spectator, or any other person, and arising from or relating to my (and/or my child's) participation in the Activity, including claims that Pediatric Boulevard was negligent.

Additional Provisions: I (and on behalf of my child) agree that the substantive laws of North Carolina govern this Agreement and any dispute I (and/or my child) may have with Pediatric Boulevard. I consent to exclusive jurisdiction in North Carolina, and agree that any mediation, suit or proceeding must be entered into or brought only in North Carolina. Any portion of this Agreement deemed unlawful or unenforceable is severable and shall be stricken without effect on the remaining provisions.

I have read this Agreement, I understand its contents and I sign it voluntarily. I intend by this Agreement to assume all hazards and risks, release all liabilities and claims, and indemnify Pediatric Boulevard for any claims arising from my (and/or my child's) participation in the Activity. I understand that this Agreement has no expiration date and remains in effect at all times that I am (and/or my child is) participating in the Activity and will be binding on me (and/or my child), my (and/or my child's) family members, heirs, assigns, executors, representatives, and estate.

CONSENT FOR PHOTOGRAPHY/VIDEO CLIPS

I understand that I will not receive any financial compensation for providing this consent. Pediatric Boulevard, PLLC will not condition treatment or payment on your providing this consent. I acknowledge that Pediatric Boulevard, PLLC cannot protect against the possibility of re-disclosure of this information and may no longer be protected by law. I understand that I can revoke my consent at any time by providing written notice. I understand that this consent expires in 5 years, unless specified by the parent/guardian. I understand that Pediatric Boulevard does not allow parental videotaping of my child's session due to HIPAA regulations, however, I may request that my therapist video tape portions of my child's session, which is the at the discretion of the individual therapist.

EMAIL AND TEXT MESSAGE AUTHORIZATION

I understand that:

(1) I have the legal right to only communicate with Pediatric Boulevard, PLLC staff using methods that protect the privacy of my (or my child's) Protected Health Information.

(2) I understand that communicating by email or text message is not secure. It is possible for people to intercept or read email or text messages without my knowledge or permission. Email and text messages can go to unintended recipients. They can be stored in electronic files. They can be used as evidence in court.

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(3) If I authorize Pediatric Boulevard, PLLC staff to communicate with me using email or text messaging, I acknowledge that I do not have an expectation of secure and private communications as defined by HIPAA and other state and federal laws.
(4) Communicating by email or text messaging is optional. I understand there are alternative methods of communications with Pediatric Boulevard, PLLC staff that are more secure. I am voluntarily requesting this form of communication.
(5) I have the right to limit what kind of information staff can communicate using email or text messaging.
(6) Staff have the right to limit what they will communicate by text messaging, or to deny my request.
(7) Staff may not read email or text messages promptly, so I should call or go to the office if I need to talk with someone right away.
(8) In case of emergency, I should call 911 instead of sending an email or a text message.
(9) It is my responsibility to delete emails or text messages on my telephone or other device so that other people cannot read them.
(10) When I communicate with my therapist using email or text messaging, my therapist will record the communication in my medical record or chart, unless it is regarding appointment times.
(11) Text messaging should only be used for non-sensitive information. If my therapist tells me that we need to communicate in person or by talking on the phone, I will comply with the request.
(12) I may cancel this request/authorization at any time by notifying my therapist in writing. If I revoke my consent, it is only effective from the date my therapist receives my cancellation, and not retroactively. A revocation of my consent will not affect my ability to obtain future services. Pediatric Boulevard and its staff may also terminate this method of communication at any time, in their sole discretion.
(13) I have a right to receive a copy of this form.

I have elected to communicate with Pediatric Boulevard, LLC staff by email and/or text messaging. I understand the risk of communicating through these methods, in particular the privacy risks explained in this form. Staff is not responsible for messages that are delayed or not received. Email or text messaging is not a substitute for care and is used primarily for convenience.

SICK POLICY

Fevers are common in young children and are often a signal that something is wrong. If your child has a fever of 101.0F or higher, please keep him or her home. If your child develops a fever of 101.0F or higher while at the clinic, you will be asked to bring him/her home. If your child's fever is *less than* 101.0 F, you will be notified and you may express your wishes to the staff at that time.

Our policy is that your child must remain free of fever for 24 hours before returning to the clinic, and area pediatricians agree with this policy. This means that if your child goes home at 3:00 p.m., but still has a fever at 6:00 p.m. or later, he/she cannot return to the clinic the next day. The 24 hours begins when your child's fever has broken and remains in a normal range.

Diarrhea and Vomiting

Diarrhea due to illness is highly contagious. If your child has diarrhea, please keep him/her home. If your child has a diarrhea episode, or any uncontained diarrhea while at the clinic, you will be asked to bring the child home. Our care providers use gloves while cleaning diaper soiled accidents. Please understand that germs from diarrhea can be spread through carpets, toys, swings and direct contact. It is very difficult to keep from spreading these germs to other children.

If your child vomits while at the clinic, you will be asked immediately to pick him/her up. Please keep your child at home until 24 hours after the vomiting has stopped. When children return too soon, there is a much higher rate of recurrence and contagiousness.

Coughs and Colds

Colds are a common occurrence. However, there are some symptoms that warrant keeping a child home. These include, but are not limited to: bad cold with hacking or persistent cough, green or yellow nasal drainage, productive cough with green or yellow phlegm being coughed up. These symptoms may be present with or without a fever.

If your child has just a cold, please notify their therapist. We encourage extra fluids and proper hand washing. If there are cold medicines you know will make your child more comfortable, please administer before the therapist works with your child. If your child cannot participate in the ordinary daily routine, he/she is probably too sick to be at the clinic.

Rash

A rash may be a sign of many illnesses, such as measles or chicken pox. In infants, an external rash may be a sign that something is going on internally. Please do not send your child to the clinic with a rash until the doctor says it is O.K. to do so.

Doctor's O.K.

In some instances you will be asked to keep your child home until we have written permission from your doctor saying your child is well enough to return to the clinic. Please understand this is for your child's well-being along with the well-being of the healthy children at the clinic and their families.

Bringing Ill Children

If your child is not infectious and your doctor has said they may return to the clinic, but your child is still not feeling 100%, please see that we have everything to make him/her comfortable. Items such as extra clothing, pillows, blankets, medication, etc. are very helpful to your child.

Medications

If your child goes to the pediatrician and is prescribed medication, please keep your child home until they have completed 24 hours of antibiotic treatment. If your child is to receive antibiotics at the clinic, please bring in the *labeled* bottle from the pharmacy and a syringe or other measuring device. You can administer antibiotics and other medications to your child prior to treatment.

Contagious conditions such as Pink Eye or Lice

If your child appears to have an infectious or contagious condition, i.e. pink eye, head lice etc., you will be asked to take him/her home or to a pediatrician to get checked out. Please do not be offended if your child is too ill to stay at the clinic and you are asked to take them home.

If your child has had a rough night or previous day, please assess them before bringing them to the clinic. If you ever have any doubts about whether or not your child should be at the clinic, please do not hesitate to call and ask us. The clinic opens at 8:00 a.m. and we would be more than willing to help you make that decision before you have to drop off your child for the day.

We do understand and empathize with parents when their children are ill. It can be a very difficult, frustrating, and emotionally challenging situation when you are torn between a sick child and other obligations. Our staff also experiences these emotions and situations when they or their children are ill. These policies are designed to be fair to the ill child and their family, as well as our healthy children and their families. Please understand that we love your children and provide the best care possible for them, but we are not a sick clinic. We are hoping to control the amount of illnesses at the clinic and to keep everyone healthy and happy. If you ever have any questions or concerns, please do not hesitate to call and talk to us at any time.

We wish to express our sincere thanks to all of you who keep their sick little ones at home and comply with our policies. We appreciate your courtesy!

FINANCIAL POLICY

Thank you for choosing us as your therapy provider. We are committed to providing you with quality and affordable therapy services. Our financial policy is outlined as follows:

Proof of Insurance: We ask that you present your insurance card to us at the first visit. If you are receiving services in the home, please provide a copy of your card to the therapist upon your first visit. You may also mail or fax a copy to this office. Please update us any time you have a change to your Insurance or Medicaid. It is your responsibility to provide any information regarding a change in address, phone numbers and employment.

Payment Arrangements: Your insurance company requires us to collect any co-payments, co-insurance and deductibles. For patients with a co-payment (i.e. $15, $20, etc. per visit) OR for patients whose co-insurance is based upon a percentage of the charge OR if you have a deductible that has not been met:

In-Clinic services: we require payment at time of service

In-Home services: you will receive a monthly invoice and payment is due upon receipt

Please understand that the amounts mentioned above are examples only and are determined by your benefit plan.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid.

- **Covered services**: Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Non-covered Services**: Please be aware that some or all of the services you receive may be non-covered by your benefit plan or not considered necessary by your insurer. You agree to pay for these services in full at the time of the visit and will be reimbursed if payment is received by Pediatric Boulevard from your insurance provider.

Out of Network: Pediatric Boulevard is in-network with most insurance companies. However, there are a few we are out of network with for example: BCBSNC Local, BCBSNC Value Plans and Federated Insurance. If you would like for your child to receive therapy services, then you must agree to pay the Billing rate in full for services.

- You must submit all billing statements to Pediatric Boulevard on a monthly basis. You will be reimbursed any overpayment made.

Methods of Payment: Credit Cards (Discover, MasterCard, Visa & American Express), Cash, Checks and Money Orders.

Discharge for Non-payment: Payment for services is your responsibility. We expect payment to be timely and in full. Non-payment (by you and/or your insurance company or benefit plan) may result in discharge from therapy services.

Cancellations/No Shows: If you need to cancel an appointment please call our office 24 hours in advance. Your child is expected to have a minimum of a 75% attendance rate per month. Non-compliance with this policy may result in discharge from therapy services. A note from your child's doctor will excuse a cancellation. (Accepting multiple notes will be at the discretion of the therapist.)

Tardiness: If your child is more than 10 minutes late to 2 scheduled visits, it is equivalent to 1 cancellation. Please see above regarding the discontinuation of therapy services as a result of multiple cancellations.

Return Check Fees: All returned checks (insufficient funds, stopped checks, etc.) will result in a $35.00 fee. Returned checks will not be processed. If this should occur, any additional payments must be made by cash or money order.

Collections: In the event that Pediatric Boulevard needs to consult a Collections Agency to collect an outstanding balance, the client will be charged an additional 25% fee (or the actual fee incurred by Pediatric Boulevard, if different) on top of the outstanding balance once monies are recouped.

DISCHARGE POLICY

Pediatric Boulevard provides occupational, speech, and physical therapy services. Our therapists provide treatment based on their scope of practice and the licensure statures of each of their practicing licensing boards. Pediatric Boulevard reserves the right to discharge patients for any reason, as determined solely by Pediatric Boulevard's therapists and staff. For example, services may be discontinued for the following reasons:

- The patient has met treatment goals;
- The patient has not met treatment goals, but progress is no longer measurable and skilled therapeutic services are no longer showing documented change in performance;
- The patient's family has requested dismissal;
- The patient has demonstrated or threatened severely violent behaviors that cannot be controlled within the skillset of our licensed therapists;
- The patient has unexcused absences or tardiness which results in less than a 75% attendance rate per month as described in the Financial Policy;
- The patient has not abided by the payment obligations described in the Financial Policy; or
- There is a history of policy violations, as described below.

Discharge for Policy Violations

While Pediatric Boulevard may discharge a patient at any time, in its sole discretion, we typically follow a "three strikes" discharge policy for policy violations:

1st Violation	=	Verbal warning
2nd Violation	=	Written notice
3rd Violation	=	Discharge

Policy violations include, but are not limited to:

- Limited participation such as frequent cancellations or non-attendance to scheduled appointments;
- Failure to abide by any practice policy;
- Failure to treat property or premises with respect: We ask that you treat our clinic as you would treat your home. Please clean up after your children in the therapy rooms, restrooms and lobby.
- Failure to supervise: Children should ALWAYS be supervised in the lobby, hallways and in the restrooms. Please never leave your child unattended.
- Failure to remain on the premises: You are required to remain on the premises at all times your child is in a treatment session. Violation of this policy may result in Pediatric Boulevard reporting your absence to local authorities, and may subject you to criminal penalties as well as patient discharge.

Our goal is to make discharge from therapy a positive experience for all children. Please let us know if you need assistance regarding additional community resources that may be helpful upon discharge. Your referral source and your child's physician will receive written notification upon discharge.