14410 Metropolis Ave.
Fort Myers, FL 33912
Phone: (239) 561-2778
Fax: (239) 561-8107

# 2024 Patient Intake

Date: _____

**Patient Information:**

Name (First, MI, Last): _____ Name Child Goes By: _____

DOB: _____ Male or Female (Circle one)

Doctor: _____ Doctor Telephone #: _____

Primary Allergies: _____

**Parent/Guardian Information: Circle One: Mother Father Other_____**

Name (First, MI, Last): _____ DOB: _____

SSN: _____ Primary Phone: _____ Secondary Phone: _____

Address: _____

City/State/Zip: _____ Email: _____

Employer: _____ Position: _____

Address: _____

City/State/Zip: _____ Phone: _____

**Parent/Guardian Information: Circle One: Mother Father Other_____**

Name (First, MI, Last): _____ DOB: _____

SSN: _____ Cell Phone: _____ Home Phone: _____

Address: _____

City/State/Zip: _____ Email: _____

Employer: _____ Position: _____

Address: _____

City/State/Zip: _____ Phone: _____

**Who has guardianship / primary custody of patient (if other than biological mother and/or father)?**

_____

Please list all individuals and their phone numbers that may be transporting the patient to/from therapy.
Please include name, relationship to patient, and phone number:

_____

_____

_____

_____

_____

**Emergency Contact (not living in household):** _____

Phone Number: _____ Relationship to Patient: _____

**Insurance Information:**

Primary* Insurance Company: _____

***WE DO NOT BILL SECONDARY INSURANCE. PLEASE INFORM OFFICE IMMEDIATELY IF YOUR CHILD HAS MORE THAN ONE INSURER. THIS SIGNATURE CERTIFIES THAT YOUR CHILD HAS *ONLY* THE INSURANCE LISTED ABOVE. IF THIS INFORMATION IS NOT ACCURATE, YOU WILL BE BILLED FOR SERVICES DENIED BY YOUR PRIMARY INSURER.** If there is found to be an error on the insurer's behalf, it is the patient's parent/guardian's responsibility to resolve this error in a timely manner before services can be rendered.

_____ _____

Patient/Guardian signature Date

**Party Responsible for Payment of self-pay rates, co-pays, co-insurance or services/fees not covered by insurance:**

Mother _____ Father _____ Other (fill out below)

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

## Please read and initial as an acknowledgement of each policy:

**Notice of our privacy practices is available if the patient/guardian would like to read it

**These policies and procedures cannot be amended or omitted. Therapy services will not be initiated until paperwork is filled out appropriately.

**Medicaid Coverage (Please initial each section)**

_____ *I have been informed of Medicaid coverage requirements (i.e.: authorization requirements, etc.)*

_____ We do not supply insurance resources/services (e.g. mileage paperwork, ordering transportation services) beyond billing and claim reconciliation. It is the responsibility of the patient's parent/guardian to obtain any resources offered through their insurance carrier.

**Photo Release**

_____ I authorize SPOT Therapy Associates to take and publish photos and/or videos of my child for the purpose of marketing and promotion of the clinic (i.e. brochures, Facebook/Instagram posts, newsletters, and website content).

**Permission Advisory**

_____ I understand that if I desire to conduct any audio or visual recordings of the therapist/therapy session, I must request verbal or written permission from the therapist and the owner of SPOT Therapy Associates, as well as inform all participants; no children aside from my own are allowed in these video recordings/photos.

**Internships**

_____ SPOT Therapy accepts therapy students as a means of promoting our profession. Therapy students will be periodically involved in your child's therapy sessions.

**Student Observation**

SPOT Therapy Associates is a teaching facility. We are often sought out for observation, volunteer, and "shadowing" opportunities, as a means of learning about the Occupational, Speech, and Physical Therapy professions.

All students and volunteers adhere to all HIPAA and privacy policies established by SPOT Therapy Associates. I understand that students may be observing and participating in training activities with my child while under direct supervision of a licensed therapist.

**Parent Permission for Student Observations of their child during therapy:**

_____ _____

Patient/Guardian signature Date

**Animal Authorization**

_____ Animal therapy (dogs) is in use at this clinic. I understand there may be an animal in the same room, building, or vicinity of any therapy being provided. I hereby authorize SPOT Therapy Associates to incorporate animal therapy with occupational, speech and/or physical therapy, for the purpose of expanding my child's therapy opportunities. I have the following restrictions: _____

**Adult Supervision**

_____ All children on SPOT Therapy property require adult supervision at all times (either parent/guardian supervision or therapist supervision). It is not appropriate to leave children alone in the waiting area/bathrooms/parking lot and it is NOT SAFE to allow them to roam unsupervised in the treatment rooms, gym area, kitchen, or parking lot, especially if interfering with office or therapy activities.

_____ Any mess, whether toys, books, or food, should be cleaned up before leaving the facility. If supplies are required for clean-up, the office staff can supply these items with the expectation of the item's return. Respect of the facility and its cleanliness is of the utmost importance.

**Items Brought into the Clinic**

_____ Spot Therapy is not responsible for any toys, clothing, pacifiers, bottles, thermoses etc brought into the therapy session. Any supplies such as diapers, wipes etc should be contained in a small backpack with the child's name clearly labeled.

**Required for Therapy**

_____ If your child requires food during the therapy session, either as a snack or as a therapy implement, it is the responsibility of the parent/guardian, not the facility, to supply the child with these foods.

_____ **If your child is not fully potty-trained, it is imperative that a bag containing diapers, wipes, and a change of clothing is provided to the therapist at every session. The facility does not supply these materials.**

_____ To prevent injury and to allow for full participation in therapeutic activities, appropriate footwear—sneakers with socks—should be worn at all times. **Sandals or crocs of any style or material are never permitted.**

_____ If your child has ever experienced a seizure or seizure-like activity you are required to provide the office with a seizure protocol for our records. We will not see your child for therapy services until a protocol is received!

_____ All demographic information will be provided to emergency medical services, if necessary, in emergency situations.

**Documentation Requests**

_____ Any documentation (e.g. tax forms, letters for school (not including excusal notes), forms/letters for legal purposes, etc.) requests should be placed with the office with at least **one-week notice**, with all of the information and materials we may require to complete the request.

_____ There will be up to a $40.00 fee assessed for more involved documentation requests that the therapist/office may need to complete, such as Special Equestrians Evaluation, grant letters, equipment recommendations, etc. These services are not covered by insurance or Medicaid and require extra therapy time to complete. Please be advised that payment is due at the time of service.

_____ There will be a fee of $0.50 per page for any copies made of patient records beyond the evaluation/Plan of Care.

_____ All evaluations and assessments require extensive medical history review, test scoring, and report writing. Please allow up to two weeks before requesting evaluation reports, to give the therapist ample time to finish their report.

_____ The owner reserves the right to terminate services immediately if applicable.

**Injuries During Therapy**

_____ If a child is injured during therapy, the child's therapist will assess the injury, apply appropriate first aid, and notify the parent. The incident will be documented by the therapist and any other therapists/staff that might have witnessed the incident.

## SPOT THERAPY ASSOCIATES FINANCIAL POLICY

**PURPOSE**

SPOT Therapy Associates is committed to providing quality and affordable care to patients it serves. We respectfully require payment by all individuals **at the time** services **are rendered**.

**POLICY**

To ensure all patient balances are appropriately billed and collected, the following guidelines are to be followed during the billing and collection process:

## INSURANCE POLICIES

SPOT Therapy Associates participates in most insurance plans. SPOT Therapy Associates will bill the patient's insurance company as a courtesy. Insurance claims will be filed daily by our billing representative. The patient's insurance company may request patients to supply certain information directly; it is the responsibility of the patient to comply with their request. The patient is directly responsible for the balance of their claim whether or not their insurance company pays the claim. The patient's insurance benefit is a contract between the patient and the insurance carrier; SPOT Therapy Associates is not a party to that contract.

**Out-Of-Network Insurances**

_____ We are considered in-network with MOST major insurance companies; however, if you carry an insurance we do not contract with, we will charge the self-pay rate for services and submit claims to the insurer. If the insurer does pay for the service, we will reimburse you up to the self-pay rate (less the insurer's determination of patient responsibility). Any additional paperwork that an out-of-network carrier may need to process the claim will be the responsibility of the insured to provide to the out-of-network insurance company.

**Co-Payments and Deductibles**

_____ All co-payments and deductibles must be paid at the time of service. This arrangement is part of the patient's contract with their insurance company. SPOT Therapy Associates cannot interfere with this contractual relationship. SPOT Therapy Associates is unable to bill secondary insurances for co-pays, cost shares, and deductibles. This would be the responsibility of the patient's parent/guardian.

**ADOS Assessments**

_____ ADOS Assessments will NOT be billed to insurances due to the lack of a specific billing code. ALL ADOS appointments will incur a $75.00 non-refundable deposit due at the time of scheduling. The remaining cost of the assessment, $200, will be collected at the time of service.

**Non-Covered Services**

_____ Some, if not all, services a patient might receive at SPOT Therapy Associates may be non-covered or deemed medically unnecessary by the insurer. In this case, the cost of the service is the responsibility of the patient's parent/guardian.

**Proof of Insurance**

_____ A current copy of the patient's valid insurance card, as well as the patient's or patient's parent/guardian's government-issued proof of identity, is required upon the first encounter with a therapist (this is generally the initial evaluation). A copy of the insurance card and proof of identity of the patient's guardian is required to be provided to our therapy facility at the beginning of the new year along with updated intake paperwork.

_____ Any correspondence/notices from the insurance carrier, or governmental agency, concerning coverage changes must be brought to the attention of SPOT office staff immediately. If there is a change in or loss of coverage, the cost of the therapy visits attended while uninsured will be the responsibility of the patient's parent/guardian. In this way, it is always best to warn the office *ahead of time* if you expect a change.

**Methods of Payments**

_____ SPOT Therapy Associates accepts payments by cash, check, VISA, MasterCard, and Discover. We have the ability to save credit/debit cards on the patient's account, if the parent/guardian chooses. The information on the card will be encrypted and protected from tampering.

_____ If you choose to not put a card on file, it is your responsibility to bring payment to the office at the time of service and make your payment. Payment is due at the time of the visit or the therapy visit will be cancelled.

_____ Payments are not taken automatically; office manually takes them. Although we do our best, at times payment may be taken late. Please review emailed receipts for information about your payment.

**Patient Invoices**

_____ Unless other arrangements are approved by SPOT Therapy Associates, the balance of the patient's invoice is due upon issuance of an invoice. If the balance is not paid in full within 30 days of issuance, the account will be sent to collections and incur an *additional* 30% charge beyond the principal balance.

**BCBS, Key Benefit Administrators, Aetna and other Commercial Insurances Member Specific**

_____ Due to the BCBS reimbursement reduction policy, SPOT Therapy Associates will allow commercial insurance members only one therapy visit per day. Commercial insurance coverage for specific therapies varies from therapy to therapy and is often based on your child's diagnosis*. Each commercial insurance plan is different in what it will and will not cover. **It is the patient's responsibility to:**

- **Keep track of the amount of therapy visits provided versus amount allowed per insurance plan.**
- **Verify that the patient diagnosis is covered under the member policy.**
- **If there is a diagnosis of Autism or Down Syndrome: verify whether the plan follows the Florida mandate, which does not allow the plan to limit services for those diagnoses.**
- **Notify our facility if prior authorization for services is required.**
- **Notify the office if there is a change in plan and/or member ID number immediately.**

***Diagnoses indicating a developmental delay of any kind, as well as most diagnoses related to speech are generally not accepted by BCBS, Aetna and other private insurances for Speech Therapy services. Patients may have their claims denied for this service.***

**Denied Claims**

_____ In the event a service is denied by insurance, an appeal will always be filed by our facility on behalf of the member. In the case that the appeal is unsuccessful, patients covered by commercial insurance should be prepared to cover the entirety of the cost of the visit, based upon the contracted rate for that service.

**Nonpayment**

If the patient's account is past due 30 days or greater and the balance has not been paid in full or payment

arrangement made, the account may be sent to collections. In the event that the patient's account is balanced with a collection agency, a collection fee in the amount of 30% of the then outstanding balance will be added to the patient's account and shall become a part of the TOTAL amount due. Until balances are paid in full, therapists will treat patients on an emergency basis for previously treated injury or problem. Any allowed visits will require cash or credit card payment in full at the time of service, unless they have valid insurance. Patients may be terminated due to non-payment. If the patient has filed bankruptcy during the course of treatment, any future visits need to be paid by cash or credit card if the patient does not have valid insurance. If there is valid insurance, any co-payments or deductibles need to be paid at the time of service.

**Patient Signature in acknowledgement of Nonpayment policy:**

_____ _____

Patient/Guardian signature Date

**Divorce/Separate Households**

_____ In the case of divorce or separation, the party responsible for the account balance is the parent authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Personal Injury Cases**

_____ In the case of patients that are being treated as part of a personal injury lawsuit or claim, SPOT Therapy Associates requires verification from their attorney prior to their initial visit if applicable. Payment of the bill remains the patient's parent/guardian's responsibility. SPOT Therapy Associates cannot bill the patient's attorney for charges incurred due to the personal injury case.

_____ I hereby assign and set over to SPOT Therapy Associates, all claims damages, and causes of actions for the same arising out of any accident creating the need for me to have physical, occupational, speech therapy services, or massage therapy services to the extent of any unpaid balance due to SPOT Therapy Associates, for physical, occupational, speech therapy services, or massage therapy services. I understand this assignment does not relieve me of any obligation to pay SPOT Therapy Associates myself.

**Returned Checks**

A $35.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to make payment for all future services at the time of service by cash or credit card.

**Credit Balance Refunds**

SPOT Therapy Associates will make a good faith effort to capture all accounts that have been overpaid by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame.

A refund will be issued when:

- A patient paid more than was based on their contractual agreement with their insurance carrier, and there is no other outstanding balance due by that patient to which the credit can be applied.
- A patient or insurance carrier erroneously issues a duplicate payment
- A payer erroneously remits payments to the wrong provider.
- The payer originally remits payment for a service that is later determined to be a non-covered service. In the situation, a refund may need to be issued to the payer, and a bill issued to the patient's parent/guardian if said non-covered service is deemed by their insurance to be a patient's parent/guardian's responsibility.
- Refunds will not be issued:
    - If insurance is pending payment
    - When there is a pre-existing balance due on the patient's account.

- Parent choses to use any credits for future appointments.

**I have read and understand Spot Therapy Associates financial policy and agree to the terms and conditions therein.**

_____ _____

Patient/Guardian signature Date

**Scheduling**

_____ Although we do our best to accommodate our client's schedules, we are unable to guarantee back to back services for children receiving therapies from multiple disciplines. We have an extensive waitlist to schedule services.

**SICK CHILD POLICY**

_____ All patients should be fever free and symptom free for at least **24 hours** before returning to therapy. Family members of patients must also be fever free and symptom free for at least 24 hours before entering the facility. As we serve medically fragile children, infants, and require healthy therapists and staff to do so, we ask that this policy is followed. It will be strictly enforced. If a parent allows a child to receive therapy in a condition other than what is described above, the child will be promptly delivered back to the parent with the expectation of no future non-compliance.

**CANCELLATION/NO SHOW POLICY**

Due to the importance of following the plan of care recommendation for frequency of services, as well as the high demand for therapy services, all patients are subject to the cancellation policy. Inconsistent attendance hinders your child's therapeutic progress in many ways, including:

- Child/therapist relationship rendered unestablished and unproductive
- Diminished progress toward therapy goals
- Regression of progress already made
- Missed opportunities for home education by our therapists
- Insurance denials due to inconsistency of treatment

**In cases of unforeseen circumstances/sick child, cancellation notice must be given by 9:00 am for morning appointments and 12:00 pm for afternoon appointments.** Cancellations due to illness will require a doctor's note (refer to our Sick Child Policy) to resume therapies. **Three or more missed visits within a 6-month period** may result in discharge from services. A maximum of two no-shows will be allowed before discharge from services. **Please make every attempt to schedule other medical appointments around your scheduled therapy appointments.**

If you plan to cancel for a period of **two or more weeks** (unless due to illness), for extended vacations, loss of insurance, etc., we cannot hold your child's appointment time until you return and therefore will be placed back on the waiting list. In the case of loss of insurance coverage, you may contact our office to schedule therapy services once coverage has been re-established. In the meantime, your child will be moved to the waiting list.

**I have read and agree to this policy and will adhere to the stipulations as outlined above.**

_____ _____

Patient/Guardian signature Date

**No Call No Show Policy**

_____ All No Call No Show appointments will be charged a $50.00 fee.

**LATE POLICY**

**Notification of late arrival to therapy, to either the office or to the therapist directly, is REQUIRED.** If a patient is 15 minutes late, the session will be cut down to end at the same time as scheduled, not extended to the original

length. If a patient arrives, or expects to arrive, 30 or more minutes past the scheduled start time, the session will be cancelled and marked as an unexcused cancellation. This, of course, does not apply to emergencies; however, notification is still required in these cases. It is at the therapist's discretion to cancel the session if the child arrives more than 15 minutes late to their appointment. **Excessive tardiness puts your child in jeopardy of losing their therapy time and being placed on the waitlist or being discharged from the practice.**

If parent/guardian leaves the facility during their child's session(s), they **must return to the facility no later than 20 minutes before the end of session** (final session if child receives more than one therapy). The final 5-10 minutes of the session will be utilized by the therapist to discuss with parents/guardians the day's activities, at-home activities, overall progress, and other important matters. As our therapists are booked back-to-back, it is paramount that sessions start and end on time. For this reason, a late fee of $1.00 per minute will be strictly enforced. This fee is not a billable charge and will not be covered by insurance. **We urge parents to avoid venturing more than 10 minutes from the facility, in case of an emergency. If your child has been assigned a nurse, the nurse should NEVER leave the facility while the child is in therapy. Spot Therapy does not have the staff to provide childcare to patients. Please be on time to pick up your child.**

_____ _____

Patient/Guardian signature Date

## AUTHORIZATION TO RELEASE AND/OR EXCHANGE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Social Security #: _____

I request and authorize _____ to release healthcare information/educational information of the patient to be used by, exchanged with, or disclosed to:

**SPOT THERAPY ASSOCIATES**
14410 Metropolis Ave.
Fort Myers, FL. 33912
Phone: 239-561-2778 Fax: 239-561-8107

**The request and authorization apply to:**
Healthcare information and educational information relating to the following: treatment, condition, and/or date, evaluations, consultations, diagnostic testing results, medications, educational planning, and continuity of care. This release allows all parties to exchange information via fax, email, verbal communication etc.

This information for which I'm authorizing disclosure will be used for the following purpose:
- **Sharing with other health care providers and school district personnel as needed.**
- **Maximize communication with therapeutic interventions and physician recommendations and guidance.**

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- Unless I specify differently, this authorization will expire twelve (12) months from the date signed below.

Patient/Patient's Parent/Guardian Signature: _____ Date: _____