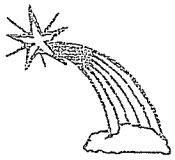
# Central Florida Pediatric Therapy Associates

*where we instill . . .*



Homebound
Occupational, Speech and
Physical Therapy
Early Intervention

352/394-0212
352/241-6361 Fax

P.O. Box 120547
Clermont, FL 34712-0547

Welcome to Central Florida Pediatric Therapy Associates. We are glad you chose us to provide intervention for your child. Enclosed you will find documents for your review which need to be signed an returned to our office before services can begin.
If scan/emailing is a better option for you, please email to hope4kids@cfl.rr.com.
Upon receipt of the signed documents, we will forward your referral on to the therapist and they will contact you regarding the schedule. Scheduling is solely between you and the therapist.

We would also like to introduce you to the non-profit organization provides recreational/sport and fitness activities. We offer therapeutic horseback riding/hippo therapy, Tae Kwon Do and Dance classes in the Clermont area. Visit our website at www.faithprojects.org for more information.

We look forward to serving your child.
If you have any questions, please feel free to call the office at 352-394-0212

Thank you,

Amy J Gomes, President

Please RETURN this page

## New Patient Information Sheet

Date: _____ E-mail Address_____

Patient's Name: _____

Last First Middle Initial

Address: _____

Number & Street City State Zip

Phone Numbers: Daytime:_____ Evenings:_____

Date Of Birth:_____ Marital Status:_____

Employer: _____

Business Address: _____

Social Security Number: _____

Type of Insurance: _____

Policy Number: _____

Date Referral Received:

Pediatrician details(name address, phone number):

Please Answer the Following Questions

1. Are you presently taking any medication?
   If yes, please list_____
2. Are you allergic to any medication?
   If yes, please list_____
3. Are you currently under the care of a doctor for any reason?
   If yes, please explain_____
4. Have you been hospitalized in the past five years for more than two days?
   If yes, please explain_____
5. Please circle any of the following, which you have had

| | | | |
|---|---|---|---|
| Anemia | Cardiac Pacemaker | Heart Trouble | Rheumatic Fever |
| Arthritis | Convulsions | Hepatitis | Sinus Trouble |
| Asthma | Diabetes | High Blood Pressure | Stroke |
| Any Blood Disease | Epilepsy | Jaundice | Tuberculosis |
| Bleeding Problems | Glaucoma | Kidney Problems | Ulcers |
| Cancer | Heart Murmur | Psychiatric Treatment | X-Ray Treatment |

6. Any other serious illness? _____

Signature of Responsible Party: _____

Please RETURN this page

## HIPAA AUTHORIZATION FORM

1. I hereby authorize the use or disclosure of my protected health information as described below.

Individual: _____ ID Number: _____

Persons or organizations providing information: Persons or organizations receiving information:

_____ Primary Care Physician:

C. F. P. t. A.

Description of information to be disclosed (including dates of service): _____

Medical + Billing

Describe the purpose or intended use of information: _____

(Note: "at the request of the individual" is adequate if the individual initiated authorization without a stated purpose.)

2. COMPLETE THIS SECTION IF HEALTHCARE PROVIDER REQUESTED AUTHORIZATION.

Healthcare provider: Will the healthcare provider receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes____ No____

Individual: I understand that I get a copy of this form after I sign it. initials: _____

3. YES, YOU MAY DISCLOSE INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH: YES Initial: _____ NO, DO NOT Initial: _____

4. I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Initial: _____

5. I understand that this authorization will expire on the following date ___/___/___ (D/MM/YR) or with the following event: upon goals reached

6. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Initial: _____

_____ _____

7. Signature of patient or patient's representative Date

Printed name of patient's representative: _____

Relationship to the patient: _____

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Note that signature or initials are required in four places.

*A copy of this completed, signed and dated form must be given to the Individual or other signatory.*

PLEASE COMPLETE this form in its' entirety and RETURN THIS PAGE.

1. Mail To: PO BOX 120547 Clermont, FL 34712
2. Fax To: 352-241-6361
3. Email To: hope4kids@cfl.rr.com

## ASSIGNMENT OF BENEFITS

In order for Central Florida Pediatric Therapy Associates to bill Medicare and/or other Insurance for therapy evaluations, treatments, and medical equipment, this form must be completed, signed, dated, and returned immediately.

**Without the signed and dated form on file, we cannot begin evaluation, treatment, or supply medical equipment that is ordered.**

I understand by signing this form, I am authorizing the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental and other insurance benefits to Central Florida Pediatric Therapy Associates for evaluations, treatments, and medical equipment furnished to me by Central Florida Pediatric Therapy Associates and/or any of their corporate affiliates.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurer(s) and their agents and assigns, as needed for the limited purpose of processing payments, treatment, or Central Florida Pediatric Therapy Associates operations.
4. Central Florida Pediatric Therapy Associates and/or any of their corporate affiliates to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for evaluation, treatment, and/or medical equipment provided.
5. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include, but not limited to, co-payments and deductibles.
6. I understand that a verification of benefits will be provided by Central Florida Pediatric Therapy Associates but this is not a guarantee of payment as it remains subject to benefit limits, exclusions, and eligibility.
7. PRIVATE INSURANCE holders must choose ONE option below:
   - __ I agree to BEGIN services prior to receiving a PRE-DETERMINATION from my insurance company. I understand that by agreeing to begin services prior to a determination of coverage, I may be responsible for all services rendered at PRIVATE PAY RATES.
   - __ I agree to WAIT for services to begin until a PRE-DETERMINATION is received for therapy. I understand this process may take a minimum of 14 days or longer to obtain a determination from the insurance company.
8. Central Florida Pediatric Therapy Associates and/or any of their corporate affiliates to contact me by telephone or mail regarding evaluations, therapies, and/or medical equipment.

Best Contact Number: (____)_____

Insurance (Other than or in addition to Medicare/Medicaid):
Insurance Name: _____
Insurance Phone #: _____
Insurance Policy #: _____
Insurance Group #: _____
Insurance Plan #: _____
Name of Insured: _____
Relationship to Insured: _____

Patient ID#: _____
Patient Name: _____
Street Address: _____
City: _____ ST: _____ Zip: _____

Signature: _____ Date: _____ Signature: _____ Date: _____

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**OFFICE COPY**

# Cancellation/No-Show Policy

There is a policy that maintains that there are allowances of only 3 "no-call, no-show" OR 3 missed appointments within a 4 week time span at Central Florida Pediatric Therapy Associates.
There may be occasions when you cannot keep an appointment and a quick phone call to the scheduled therapist's cell phone will suffice. Please ask your therapist for their cell phone number and keep it handy for such occasions. You can also call the office at (352) 394-0212 and the message will be passed on to the therapist. If therapy is at the Dreamplex, please call (352)404-4085

Please keep in mind that the therapist needs as much time as possible to re-arrange their schedule if a cancellation is made. As soon as you see that a cancellation will be necessary, please call the therapist directly, or call the office so that the therapist does not make the trip in vain. The travel time and missed appointment cost the therapist personally and Central Florida Pediatric Therapy Associates corporately.

Central Florida Pediatric Therapy Associates reserves the right to bill a $25.00 cancellation fee if treatment is not cancelled in a timely manner (at least 2 hours prior to the schedule time).

Your child's therapy is important and continuity of care is essential to achieving their established goals and to assist in achieving their optimal development.

I hereby acknowledge the receipt of the cancellation policy.

Parent signature _____ Date: _____

Childs Name: _____

***PLEASE RETURN TO OUR OFFICE***

Thank you,
Central Florida Pediatric Therapy Associates

# Central Florida Pediatric Therapy Associates

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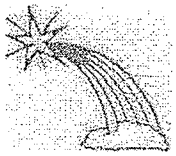

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Thank you,

Amy Gomes, PT

Amy J Gomes, President

CENTRAL FLORIDA DREAMPLEX
ORDINARY SPORTS FOR EXTRAORDINARY PEOPLE

# Central Florida Dreamplex Rules

1) All members, guests, and therapy patients must check-in at front desk at the beginning of each visit.
2) Non-members and siblings of those receiving therapy are not permitted on any equipment and must wait quietly in one of the two waiting areas. All children should be supervised by a parent/caretaker at all times when not receiving treatment.
3) Equipment is for use by registered guests and members only. This area is not supervised.
4) Participation in exercise and fitness programs is done at your own risk. Central Florida Dreamplex is not responsible for any injury that may occur to individuals participating in any exercise activity. Medical clearance before participating is highly recommended.
5) Participants with developmental delays must be supervised at all times. Supervision can come from a parent/guardian, a personal assistant, a therapist, or from an instructor during a class or other program for which the child is enrolled.
6) Closed-top athletic shoes and proper athletic attire is required.
7) Water and sports drinks are permitted provided they are in a sealable non-glass container.
8) Food, gum, tobacco products, smoking, and alcohol are not permitted.
9) Personal effects must be stored where they do not interfere with classes or those using equipment. We are not responsible for any lost or stolen property.
10) The Central Florida Dreamplex reserves the right to refuse service to any member or visitor who violates any rule or regulation, or engages in any verbal and/or physical abuse of staff or other members.
11) A maximum of 6 users are allowed on the rock wall at any given time.
12) No users under the age of 12 are allowed on the rock wall without supervision from a therapist, adult volunteer, or staff member.
13) No users are allowed on any equipment without assistance from an adult therapist, volunteer, or staff member.
14) Only one user per piece of equipment at any time.

I certify that I have received a copy of the Dreamplex Rules and have read and understand them. I hereby waive, release, and discharge Central Florida Dreamplex from any and all liability.

_____ _____

Parent Signature Date