Mini Miracles

PEDIATRIC THERAPY

Estimated Costs for Treatment

I understand this is an estimate of costs only. I understand I am responsible for payment each day of service.

Patient Name/DOB: _____

Insurance Company: _____

Estimated Cost: _____

Deductible Amount: _____

Deductible Applied: _____

Visit limit (if applicable): _____

Co-insurance/Co-pay Amount: _____

Signature: _____

Date: _____

Registration, Billing and Collection Payment Policy

We are participating with Tennessee Medicaid, Virginia Medicaid, and Most Managed Care (commercial insurance) plans in the area. As a courtesy, we will file these claims for you. Patients are expected to pay any deductibles, coinsurance or copayment amounts owed at the time of service.

Patients with a third party coverage with whom we do not contract are responsible for payment in full at the time of service. As a courtesy, we will file your charges with this third party payer upon receipt of payment in full. Otherwise, we may provide you with a completed third party payer claim form to use in filing your insurance.

Patients that have not met their annual deductible amount on the date of service will be asked to pay Mini Miracles' estimate of the allowed charge at the time of service. You will be billed for any additional deductible amounts after the insurance processes the claim. After the deductible amount has been met, payment will reflect the appropriately allotted coinsurance amount.

Patients without verifiable insurance will be responsible for payment of all services rendered at the time of service following the Self-Pay Agreement Form.

Please realize, however, that:

- Your insurance is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance benefits and the portion you are liable for.
- Depending on the specifics of the agreement we have with your insurance company, any portion of our fees not covered may be the responsibility of the patient/guarantor.
- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. Any service not covered is the responsibility of the patient/guarantor.

Regardless of insurance payment, the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. We realize that some balances may not be able to be paid in full at time of service. Please speak with the clinical director and sign the Payment Plan Policy and we will be happy to assist you in making payment arrangements.

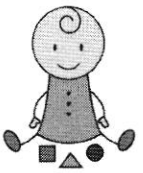
❑ My child is a Katie Beckett Waiver recipient. Caseworker _____

❑ My child is enrolled in Tennessee Early Intervention. Caseworker: _____

By signing this financial policy acknowledgement of the financial responsibility is accepted. This will remain in effect until revoked in writing.

Parent/Guardian Signature: _____

Date: _____



Mini Miracles

PEDIATRIC THERAPY

Patient Responsibility Agreement

Insurance Benefits

As a courtesy, our organization files insurance benefits on behalf of the client. It is the responsibility of the parent/guardian to ensure accurate insurance information is updated and on file at all times. Initial coverage information (primary, secondary, filing information) is obtained through this initial packet and will be updated yearly. Should you have any change to insurance coverage, please notify the front desk immediately to ensure proper billing.

Once payment amount is determined from the insurance, the parent/guardian is responsible for the remaining balance which may include deductible, co-pay, or co-insurance amount.

It is our policy for patient responsibilities to be paid at the time of service.

Private Pay

If you have chosen self-pay as the option for services, these payments are **due at the time of service.** You may also set up a plan to pay proactively each month if you prefer to pay in one large sum. Any remaining balance will be billed to you via monthly statement which will be due upon receipt of statement.

Monthly Statements

Any remaining balance will be placed on a monthly statement which is emailed to the email on file on the 5th of each month. This statement will list any remaining balance and include payments made to the account. **This balance is due upon receipt of the statement.**

Missed Payments

Should a payment be missed at the time of service, we ask that you make up this payment at the next time of service. **If payments are not received for a period of one (1) month OR if a balance of $350 is accrued at any point, a discussion will be initiated regarding prompt payment.**

If a balance reaches $500, there will be a discussion regarding a plan for paying balance in full and next steps for services which could include a change in the frequency of the plan of care or a hold on services. You will receive one courtesy text message alerting you to the effective date for the hold.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____

Mini Miracles Pediatric Therapy

Outpatient and Telehealth

Cancellation / No Show Policy

- If you need to cancel, please do so **at least 24 hours** prior to your scheduled appointment.

- If you **cancel more than 20%** of your scheduled appointments, in person or telehealth, your child will be dropped from the schedule. This will be calculated quarterly, and we will notify you by letter that you have exceeded the 20% rate. **This includes all missed visits (sickness, medical appointments, vacations, etc.); there are no excused and unexcused cancellations.** Please use missed visits wisely so that the 20% isn't an issue. All therapies will be totaled together and the child will be discharged from all disciplines if the percentage missed is greater than 20%. If you anticipate missing greater than 20%, please ask to be put on hold for therapy until you are able to come 80% of the time. **Therapist and clinic cancellations do not count in this percentage.**

- If you "**no show" for 2 appointments** your child will be dropped from the schedule. If this occurs, we will notify you by letter that your child has been dropped from the schedule.

- **Please be punctual**. If you are late for your scheduled appointment, it is at the therapist's discretion if you receive treatment that day. **If the therapist is unable to provide treatment that day, it will be counted as a cancellation.**

Patient name: _____

Parent's Signature: _____ **Date:** _____

2214 East Fairview Avenue Johnson City, TN 37601 Phone: (423) 928-6464 Fax: (423) 232-7970
225 Midway Medical Park Bristol, TN 37620 Phone: (423) 797-4555 Fax: (423) 797-4556
Email: office@minimiraclespllc.com

OUTPATIENT
PATIENT HISTORY QUESTIONNAIRE

Date:	Date of Birth:
Child Name:	Diagnosis:
Primary MD:	Referring MD:

INSURANCE INFORMATION

Primary Insurance:		Member ID/Group ID:
Subscriber's Name:	DOB:	Social Security Number:
Secondary Insurance:		Member ID/Group ID:
Subscriber's Name:	DOB:	Social Security Number:
Responsible Party: Phone:	Address:	

CONTACT INFORMATION

Mother:	Phone:
Father:	Phone:
Other:	Phone:
Address:	
Email address:	
Is this child in the foster care system? ☐ Yes ☐ No IF YES, DCS CASEWORKER NAME:_____ PHONE:_____	
Is your child in Early Intervention? __YES __NO	Service Coordinator:

MEDICAL HISTORY

Allergies:_____ _____ _____	Current Medications: _____ _____
Birth History: ____ Full Term ____ Premature at _____ weeks.	Birth Complications: _____ _____ _____

PATIENT HISTORY QUESTIONNAIRE (continued)

Medical History: *Has your child ever had any of the following??*

Cardiac/ Heart Defects	□ NO □ YES-when_____
Diabetes	□ NO □ YES-when_____
Asthma	□ NO □ YES-when_____
Lung Disease	□ NO □ YES-when_____
Kidney Disease	□ NO □ YES-when_____
Hearing Loss	□ NO □ YES-when_____
Vision Problems	□ NO □ YES-when_____
Frequent Ear Infections	□ NO □ YES-when_____
Frequent Respiratory Infections	□ NO □ YES-when_____
Reflux	□ NO □ YES-when_____
Seizures/Epilepsy	□ NO □ YES-when_____
Birth Defects	□ NO □ YES-when_____
Bleeding Disorder	□ NO □ YES-when_____
Blood Clotting Disorder	□ NO □ YES-when_____
Fractures	□ NO □ YES-when_____
OTHER:_____	□ NO □ YES-when_____

Surgeries: *Has your child had surgery for any of the following?*

VP Shunt	□ NO □ YES-when_____
Heart	□ NO □ YES-when_____
Tonsils	□ NO □ YES-when_____
Eyes	□ NO □ YES-when_____
Ears/ ET tubes	□ NO □ YES-when_____
Kidney	□ NO □ YES-when_____
Stomach/Gastrointestinal	□ NO □ YES-when_____
Appendix	□ NO □ YES-when_____
Hernia	□ NO □ YES-when_____
Orthopedic surgeries: what?_____	□ NO □ YES-when_____
Other:_____	□ NO □ YES-when_____
Other:_____	□ NO □ YES-when_____
Other:_____	□ NO □ YES-when_____

I agree that the information above is accurate and complete to the best of my knowledge.

Parent/Guardian Signature_____

Relationship_____**Date**_____

CHILD'S NAME: _____ **DOB:** _____ **MMPT#:** _____

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PERMISSION TO TREAT AND BILL INSURANCE/FINANCIAL AGREEMENT

CONSENT TO PHOTOGRAPH

I understand that photographs, video, and/or digital images may be made or recorded during therapy to document progress or for educational purposes. I understand that Mini Miracles Pediatric Therapy (MMPT) will keep such information confidential and will maintain my privacy. Such videos/pictures will be kept for a length of time according to the law and families can request copies of them. Pictures or videos that identify you/your child will only be released or used only upon written authorization for purposes such as lecturing/marketing.

AUTHORIZATION OF BENEFITS/MEDICAID INFORMATION

I authorize payment directly to Mini Miracles Pediatric Therapy (MMPT) from my insurance company or third-party payor. I authorize MMPT to secure information from the Department of Human Services regarding my Medicaid Eligibility. I authorize MMPT to bill Medicaid for rendered services.

IF insurance is not being billed, I will pay for services rendered on the day of treatment.

RELEASE OF MEDICAL INFORMATION

I authorize MMPT to release any medical/treatment information to my/my child's insurance company, my child's physician, Early Intervention providers, as well as any other service provider on my/my child's treatment team to share medical/treatment information pertinent to the plan of care or billing.

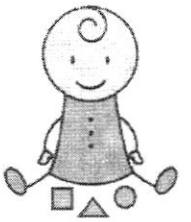
CONSENT TO TREAT

I authorize MMPT to assess and provide ☑ *occupational*, ☑ *physical*, ☑ *speech*, and/or ☑ ABA therapy treatment necessary to improve my/my child's functional, developmental, or medical level of functioning.

Parent/Guardian Signature_____

Relationship_____ **Date**_____

CHILD'S NAME: _____ DOB: _____ MMPT#: _____



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Release Indemnification & Hold Harmless Agreement

THIS IS A LEGAL RELEASE

Parent/Guardian Name(s):_____
Address:_____ City:_____ State:_____
Zip:_____ Email:_____
Home Phone:_____ Cell Phone:_____

NOTIFICATION OF RISK

I understand that certain risks and dangers exist in the programs and activities in which the attending adult or minor child voluntarily chooses to participate in at Mini Miracles Pediatric Therapy. These inherent risks cannot always be foreseen nor eliminated without destroying the unique character of the activities and include, but are not limited to loss or damage to personal property, accidental injury or illness of any kind, or in extreme cases, permanent trauma, disability or death.

I expressly acknowledge and assume the inherent risks identified herein and those inherent risks not specifically identified. I acknowledge that participating in the activities provided by Mini Miracles Pediatric Therapy is not compulsory, and hereby knowingly and willingly choose to participate or allow the attending minor child to participate, in spite of and with full knowledge of the risks involved.

INDEMNIFICATION AND HOLD HARMLESS AGREEMENT

Understanding the inherent risks, I individually and as the parent or legal guardian of the attending minor child, AGREE TO RELEASE FROM ANY LIABILITY AND TO DEFEND, INDEMNIFY AND HOLD HARMLESS MINI MIRACLES PEDIATRIC THERAPY and its officers, directors, employees, servants, volunteers and agents (collectively " Mini Miracles Pediatric Therapy") from any liability, claims, causes of action, demands, costs,

obligations or financial responsibility of every kind and nature, including that resulting from or arising out of NEGLIGENCE of Mini Miracles Pediatric Therapy for any incident, injury or accident occurring to myself, the attending minor child, or member of my family, while engaging in or observing any activity at Mini Miracles Pediatric Therapy. By agreeing to this indemnification, I am knowingly and willingly choosing to be financially responsible for any future claims brought against Mini Miracles Pediatric Therapy.

I acknowledge that I am voluntarily electing to allow my minor to participate in such activities for their benefit. Knowing of the risks, I hereby EXPRESSLY AGREE to HOLD HARMLESS and INDEMNIFY Mini Miracles Pediatric Therapy for any claims that may be brought by my minor child or family members.

OTHER PROVISIONS

If any part of this agreement is found by a court or other appropriate authority to be invalid, the remainder of the agreement nevertheless will be in full force and effect.

This agreement is entered into voluntarily, after careful consideration and is binding upon the persons signing below, their heirs, executors, administrators, wards, minor children and other family members.

THIS IS A LEGAL RELEASE

The undersigned parent or legal guardian represents that he or she has read this Release, has requested and been provided with, or has requested and declined advisement on the potential dangers/risks of engaging in the observation, activities, or the instruction offered, **assumes all risks associated with such dangers and risks**, and is fully aware of and understands the terms and the legal consequences of the signing of this Release. The undersigned parent or legal guardian intends his or her signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

Parent/Legal Guardian Printed Name

_____

Signature of Attendee or Parent/Legal Guardian

_____

Date_____

Witness Printed Name

_____

Signature of Witness

_____

Date_____

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Mini Miracles Pediatric Therapy or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

CHILD'S NAME: _____ DOB: _____ MMPT#: _____

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PATIENT RIGHTS

The purpose of this written statement is to inform you and/or your child of your rights as a patient. If you need help understanding this please ask your therapist.

1. You and/or your child have the right to competent, considerate, and courteous treatment without discrimination.
2. You have the right to complete information and to ask questions about all the aspects of your/your child's therapy, including all providers and charges associated with therapy.
3. You have a right to be involved in all aspects of your/your child's therapy treatment.
4. You and/or your child have the right to agree to or refuse to participate in any aspect of therapy.
5. You and/or your child have the right to assistance with communication, including an interpreter if necessary.
6. You have the right to discuss ethical issues arising in your/your child's care.
7. Your therapist is a mandatory reporter for abuse and neglect; therefore, any signs of abuse/neglect will be reported immediately to the proper authorities.

PATIENT RESPONSIBILITIES

Cancellation/No Show Policy

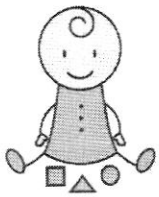
It is the responsibility of the child's family to notify the therapist if they will not be able to keep a scheduled appointment at least 24 hours in advance. (423) 928-6464.

In the event that, at the time of the scheduled appointment, the patient is not at home, or at the agreed upon location, this is considered a NO SHOW. IF this occurs twice the child will be removed from the schedule. Child may be put on the wait list if the parent or guardian calls to address the attendance issue.

CHILD'S NAME: _____ DOB: _____ MMPT#: _____

IF a child/family cancels their appointment >20% of their scheduled appointments they will be removed from the schedule. Child may be put on the wait list if the parent or guardian calls to address the attendance issue.

Parent/Guardian Signature_____
Relationship_____**Date**_____



Mini Miracles Pediatric Therapy

Mini Miracles is now offering courtesy text reminders for appointments. We need your consent and contact information for texting for you to receive these reminders.

____ I consent to text reminders ____ I do NOT want to receive text reminders

Patient name:_____ DOB:_____

Parent/Guardian signature:_____

Phone number for text reminders: _____