SOUTH COAST THERAPY
PEDIATRIC THERAPY SPECIALISTS

Dear parent,

Thank you for your interest in using South Coast Therapy, In. to provide your child's occupational, physical, and speech therapy needs. Following, please find our Information Questionnaire. We will need to receive the following documents upon your first appointment with us:

- Completed Information Questionnaire
- Insurance card
- A prescription from a medical doctor stating your child's name, diagnosis, and need for an occupational, physical, and/or speech evaluation and/or treatment.

Please arrive 15 minutes prior to your scheduled appointment with us. Directions to our facility are listed on our website, under the "Contact Us" section. Our address and phone number are also listed below for your convenience. Thank you for the opportunity to contribute to your child's care.

Best regards,

South Coast Therapy, Inc.
11205 Knott Ave., Ste. E
Cypress, CA 906030
Phone: 714-893-7399
Fax: 714-893-7389
admin@sctpeds.com

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INFORMATION QUESTIONNAIRE

Child's Information		
Last Name:	First Name:	MI:
Sex: Male Female	Date of Birth:	Age:
List Any Known Allergies:		
Parent Concerns:		

Primary Physician Information		
Last Name:	First Name:	Specialty:
Address:	City:	Office Phone:
Referring Doctor (If different than above):	Office Phone:	Office Fax:

Primary Caregiver Information:		
Last Name:	First Name:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
E-mail Address:	Relationship to Patient:	
Spouse's Name (if applicable):	Spouse's Phone:	

Insured Employer Information		
Employer Name:		
Employer Address:		
City:	State:	Zip:

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Emergency Contact Information		
Last Name:	First Name:	
Relationship: ☐ Spouse ☐ Parent ☐ Friend ☐ Domestic Partner ☐ Other:		
Home Phone:	Work Phone:	

Primary Insurance Information		
Type of Insurance: ☐ PPO ☐ EPO ☐ HMO ☐ IPA ☐ POS ☐ Medi-Cal ☐ Other		
Insurance Company Name:	Provider Phone Number:	
Policy ID Number:	Group Number:	
Policy Holder Name:	Date of Birth:	Social Security Number:
Patient Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

Patient Authorization, Release and Signature

I authorize treatment by the staff at South Coast Therapy, Inc. and authorize the release of information to other health professionals and my insurance company. I authorize payment to be made directly to South Coast Therapy, Inc.

I agree to verify this information by reading my insurance benefits book or contacting my insurance company. I do not hold South Coast Therapy, Inc. responsible for any incorrect or omitted information or for any changes in my future coverage. I understand that I am responsible for the contract between myself and my insurance company.

Patient Signature: _____ Date: _____

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Facility Policy Information:

South Coast Therapy, Inc. is committed to providing you with the best possible care. Please initial all statements that apply.

Request for Service

I hereby request South Coast Therapy to render therapy services to my child. Treatments are to be rendered by a credentialed therapist, duly qualified to treat my child. The need for such treatment has been indicated by evaluation procedures which have been reported and explained to me. Although there is a reason to believe that my child will benefit from the recommended treatment, I am aware that it is not possible for any treatment program to guarantee success. I further understand that a specific time will be reserved for my child's therapy, and I acknowledge my responsibility to insure regular attendance. Although this request for therapy covers an unspecific length of time, it may be terminated by me at any time for any reason.

Parent/Guardian's Initials _____

Financial Policy

Your understanding of our financial policy is important to our professional relationship. **These established financial policy guidelines will be followed in resolving your balance:**

Private/Self-Pay and Pending State/Local Eligibility Determination:

Patients without insurance must make suitable arrangements including a deposit at the time of service and resolution of the account with payment in full within thirty (30) days.

Parent/Guardian's Initials _____

Cash Pay

Non-covered services will be billed to me. Additionally, I have agreed to pay the full estimate of charges for this visit, as applicable.

Parent/Guardian's Initials _____

Commercial Insurance: POS/PPO/EPO/PFFS

Any co-payments, deductibles, co-insurance, non-covered services or amounts in excess of my policy's annual maximum are due and payable at the time of service. Insurances will notify South Coast Therapy, Inc. after they consider the claim for payment and then South Coast Therapy, Inc. will bill accordingly.

Parent/Guardian's Initials _____

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Out of Network/Point of Service

I am electing to use out of network or point of service coverage for today's services. I acknowledge this choice will result in higher out of pocket expenses for me.

Parent/Guardian's Initials _____

HMO

I agree to pay any co-payments, non-covered or non-authorized services, as well as amounts in excess of annual benefits, which are due and payable at the time of services.

Parent/Guardian's Initials _____

State/Local Coverage/CalOptima

Co-payments, deductibles, share of cost (SOC) or excluded services are due and payable at the time of service. Some Medi-Cal plans only cover specific types of services. I understand that I will be billed for non-covered services.

Parent/Guardian's Initials _____

Financial Agreement

I understand that even if I have insurance, I am financially responsible for the therapy services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the services received I agree to pay South Coast Therapy, Inc. for therapy services in accordance with the rates and terms of South Coast Therapy, Inc. I also understand that when this agreement is signed, I shall be jointly and individually liable for payment including all collection fees (attorney's fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

Parent/Guardian's Initials _____

Assignment of Benefits

I authorize and direct payment to South Coast Therapy, Inc. of any insurance benefits payable to me, or on my behalf, for services at a rate not to exceed South Coast Therapy, Inc.'s actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance, or other sources, may be applied to any other account owed to South Coast Therapy, Inc. by me.

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Authorizations:

Patients not confirming prior authorization and/or requesting services when authorization has been denied or has not been obtained will be billed as a private/self-pay.

Collection Measures:

Accounts unresolved within forty-five days (45) may be referred to an outside agency for further follow up, reported to the local credit reporting bureau and may result in legal proceedings. In order to make payment arrangements, please call South Coast Therapy, Inc. at 714-893-7399.

Notice of Privacy Practices:

I understand that South Coast Therapy, Inc.'s Notice of Privacy is available to me upon request and is prominently displayed in the lobby.

Parent/Guardian's Initials _____

I have read and understand the policies/statements written above.

Patient/Legal Guardian Signature: _____ **Date:** _____

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Attendance and Illness Policy:

Dear Parents,

We need your help. Regular attendance in your child's therapy sessions is important for maximum gains to be made. We must make every effort to keep missed appointments to a minimum. South Coast Therapy, Inc. will try to schedule times which are good for your child and conducive to regular attendance. We promise to make every effort to reschedule appointments missed for any reason, ours or yours.

We reserve an appointment time especially for you and your child. **Please schedule your child's other appointments (e.g., doctor's, dentist, etc.) at times other than your regularly scheduled therapy appointment to maintain continuity with your child's therapy.** If you are unable to keep your scheduled appointment, please let us know as far ahead of time as possible to assist with rescheduling. There are others who want therapy and may be able to use your scheduled time if you can't. You are expected to call and let us know if you are unable to come in for therapy, regardless of the reason. We require at least a 24 hour cancellation notice. Failure to call us and cancel an appointment will be considered a no-show.

The Regional Center of Orange County and Private Insurances allow us to charge families a reasonable fee for appointments cancelled with less than **24 hour notice**.

All non-illness related cancellations will be charged a $50.00 fee for each missed appointment.

In case of illness: If you feel that your child's illness is contagious (fever or green runny nose), PLEASE KEEP YOUR CHILD HOME. Your child will recuperate more quickly and completely with rest. Please call us as soon as you know your child is ill or first thing in the morning the day of your appointment to cancel.

Excessive absenteeism or no shows: We cannot hold appointment times open for individuals that are not able to attend on a regular basis for reasons outside of illness or hospitalizations. If you have more than three unplanned absences, miss more than three appointments without calling and notifying us, or have more than three cancellations unrelated to illness we may not be able to provide therapy for your child.

I understand the attendance and illness policy. I will call and give advance notice of cancellations when possible.

Parent/Legal Guardian's Signature: _____ **Date:** _____

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Consent for Bathroom Release

I hereby authorize South Coast Therapy, Inc to allow my child/foster child to use our restroom facilities with staff assistance/ or supervision. This includes diaper changing if required.

Parent/guardian signature_____
Date_____

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All Medi Cal patients are required to present their Medi Cal or CalOptima insurance card at your first visit.

Failure to present this secondary insurance card may result in South Coast Therapy not being able to process your secondary insurance benefits.

Parent/guardian signature_____
Date_____

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Release of Information:

I, _____ (Parent/Legal Guardian's Name) hereby consent to South Coast Therapy, Inc., giving and/or receiving information pertaining to the physical, occupational, and/or speech language therapy program for_____ (Child's Name) with the persons or agencies listed below. This may include but is not limited to Regional Center of Orange County, child's pediatrician, neurologist, gastroenterologist, orthopedist, etc. A photocopy of the document shall be considered to be valid as the original. This release shall be in effect until revoked.

Physician/Specialist	Agency	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In accordance with The Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule, I authorize South Coast Therapy, Inc. to communicate electronically via email regarding my child's therapy. I understand that therapy reports, appointment reminders and additional correspondence will be emailed to the above mentioned parent/legal guardian and Regional Center service coordinator, if applicable. I understand it is my responsibility to inform South Coast Therapy, Inc. of any changes to my email address as to avoid unintentional disclosures of medical information. Please provide your email address below.

Email Address _____

I have read and understand the information above.

Parent/Legal Guardian's Signature: _____ **Date:** _____

Printed Name: _____ Relationship**:** _____

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AUTHORIZATION TO TAKE, RETAIN, AND USE PHOTOGRAPHS, VIDEO TAPES, AUDIO RECORDINGS, AND OTHER IMAGE MEDIA

I, the undersigned, being the parent or authorized guardian of the below named child (hereinafter referred to as "Child"), authorize representatives of South Coast Therapy, Inc. to take photographs, video tapes, audio recordings, digital images, or other image media of Child and me during assessments, therapy sessions, demonstration sessions, and/or specially scheduled photography/recording sessions. This authorization is for the exclusive use of South Coast Therapy, Inc. to be used for training and educational purposes and/or for illustrative purposes in professional publications and course manuals. The authorization extends to the retention and use of such photographs, video tapes, audio recordings, digital images, or other media, and shall remain in effect without restriction until it is revoked in writing by me. All such photographs, video tapes, audio recordings, digital images and videos, or other image media and copies thereof shall remain the exclusive property of South Coast Therapy, Inc. and may not be duplicated or otherwise copied, in-whole or in-part, without the expressed written consent of South Coast Therapy, Inc.. South Coast Therapy, Inc. agrees that any use of such images or recordings shall exclude any specific identification of the Child in order to protect the privacy and confidentiality of the Child and the Child's family.

This authorization is for the exclusive use of South Coast Therapy, Inc. to be used for:

- ☐ Training and educational purposes and/or for illustrative purposes in professional publications and course manuals. With written permission of South Coast Therapy, Inc., agencies or businesses sponsoring educational courses or seminars may print educational materials containing photographs of Child in handout or manual form. These business or agencies include but are not limited to the Neurodevelopmental Treatment Association (NDTA) and other continuing education organizations.
- ☐ South Coast Therapy Inc. Website
- ☐ Instagram
- ☐ Facebook

Authorized:

_____ _____ _____
Child's Name Parent/Guardian signature Date

_____ _____
Child's DOB Print parent/guardian name

Contact Address: Phone number:

_____ _____

_____

_____ _____
Witness Date

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