JEWELS
Pediatric Therapy Clinic

5713-B Park Heights Ave Baltimore, MD 21215
Phone (410) 415-3515 Fax (443) 459-9550
www.JEWELSschool.org

Welcome and thank you for choosing JEWELS Pediatric Therapy Clinic for your child's pediatric gross motor, fine motor, and speech development needs. It is our goal to provide you with outstanding service, support, and communication regarding your child's needs. We want you to be an integral and active participant in your child's therapy and learn how to provide an environment for your child that will support his/her development.

This year all therapy services are under the JEWELS program. We are located at 5713 Park Heights Ave, Baltimore, MD 21215. Please enter from the parking lot in the rear of the building through the brown door, which has a wooden ramp and a sign that says "JEWELS Inclusive Preschool and Pediatric Therapy Clinic."

Included in our paperwork you will find:

- Patient Information Form
- Pediatric History Form
- Contract for Services
- HIPAA Policy
- Optional Credit Card Authorization Form

Please read all forms thoroughly so that you are informed about our policies. Please ask any questions to better help us serve you and your family.
Please return all forms completed and a copy of your insurance card to us via email or mail. Please include any necessary referrals or prescriptions.
We thank you for allowing us to serve you and look forward to working with you!

Please note: JEWELS Pediatric Therapy is no longer contracting through Early Steps Therapy, LLC. All therapy services will be provided by and billed through JEWELS and therefore, all clients will require new paperwork.

Sincerely,
Carin Bea Feldman, MS, CCC/SLP

Carin Bea Feldman, MS, CCC/SLP
Director of Clinical Services

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Patient Information

CHILD'S NAME: _____ AGE: _____
MALE / FEMALE DATE OF BIRTH: _____

HOME ADDRESS: _____
CITY: _____ STATE: _____ZIP: _____
HOME TELEPHONE: _____E-MAIL: _____

PARENTS NAME (S): _____
EMPLOYER: _____
WORK PHONE: _____CELL PHONE:_____

PRIMARY DOCTOR: _____
Doctor's Address: _____Phone: _____

DIAGNOSIS _____
DATE OF ONSET _____
REQUESTED THERAPY:
□Physical Therapy □Occupational Therapy □Speech Therapy

Insurance

Primary: _____
Type: □ PPO □ POS □ EPO □ HMO □ Private □ Other
Subscriber name: _____
DOB: _____
ID #: _____
Group/Plan #: _____

Secondary: (if applicable)_____
Type: □ PPO □ POS □ EPO □ HMO □ Private □ other
Subscriber name: _____
DOB: _____
ID #: _____
Group/Plan #: _____

How did you hear about JEWELS Pediatric Therapy Clinic? _____

Preferred reminder/contact method: □ text □ email □ phone (if text, please add your carrier name).

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Pediatric History/Parent Questionnaire

Prenatal History:

Birth Weight _____ Height _____ Duration of Pregnancy _____
Type of Delivery: _____
Complications at birth:

_____
_____
_____

Living Arrangement (where, with whom, siblings, pets)

_____
_____

How does your child spend their day? (Preschool, school, daycare, etc.)

_____
_____

What does your child like/dislike?

_____
_____ _____

Treatment received by child:

_____
_____ _____

Please list any injuries, illnesses, infections, hospitalizations, surgeries or other medical procedures your child has/had and the ages these occurred:

_____
_____

Does the child have any allergies, seizures or other medical problems?

_____
_____

Current Medications:

_____
_____

Is your child up to date with immunizations? Yes No

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Motor Development:
At what age did your child do the following?

Roll stomach to back _____
Sit supported _____
Crawl _____
Cruise _____
Climb stairs _____
Finger feed self _____
Drink from cup _____

Roll back to stomach _____
Sit unsupported _____
Pull to stand _____
Walk _____
Run _____
Begin eating solid foods _____
Use utensils _____

Speech and Language Development:
My Child Communicates By:
□Gestures □Eye gaze □Crying
□Sign language
□Single words □Phrases □Conversation □Augmentative Device

Can you understand your child's speech? Yes No **Can others?** Yes No
Does your child stutter? Yes No
Estimate vocabulary size: _____words
Can your child follow directions? Yes No
Answer simple questions? Yes No
Comments:_____
_____
_____

Please describe your concerns for your child:
_____
_____
_____

Is there anything else you would like us to know about your child?
_____
_____
_____

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Child's Name _____ Date of Birth_____

Contract for Services

I understand that *JEWELS Pediatric Therapy Clinic* is not responsible to verify insurance eligibility or benefits. I am responsible to confirm that they are a contracted provider with my specific insurance plan and to verify the benefits allowed for therapy services.

I understand that I am responsible to obtain a physician referral and an insurance authorization when necessary. I agree to keep track of the number of visits used relative to those authorized, the expiration date of any authorization and/or the contract limitations of my insurance plan. If progress reports and/or treatment plans are required by my physician or insurance company, I will notify my therapist at least one month before they are due, to allow time for completion of the paperwork.

JEWELS Pediatric Therapy Clinic my consent for the release of this information.
I understand that I am responsible for payment of the account and responsible to guarantee that the account is paid on a timely basis – whether payments are made by me or by my insurance company. If claims are submitted to insurance and payment is not received within 60 days, I agree to follow up with the insurance company regarding payment and to make regular payments on my account.
All co-payments, co-insurances, deductibles and balances will be collected at the time of service.

I choose to receive services from *JEWELS Pediatric Therapy Clinic* and agree to pay for the services.

_____ _____

Parent/Guardian Signature ***Date***

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Insurance waiver
(Signature required by *all insured clients* **– if claims *are or are not* submitted)**

I elect to have *JEWELS Pediatric Therapy Clinic* provide therapy services for my child. I understand that if my insurance company does not allow benefits or approve payment of claims for services my child has received. *I am responsible for all incurred charges and I agree to pay the balance in full.*

I understand that even when therapy services are listed as being a covered medical expense on my insurance plan – payment is not guaranteed. Upon receipt of claims for services rendered, my insurance company will complete a review for medical necessity and based on that review (related specifically to my child) the services *may not be considered to be medically necessary or may be* considered as *non-covered expenses* and may not paid by my insurance company.

_____ _____
Parent/Guardian Signature ***Date***

Cancellation/Lateness Policy

I understand that with the exception of emergency or illness, I am required to notify the practice a minimum of 48 hours prior to any cancelled or missed appointments. If I do not provide 24-hour notices, then I will be charged $25 for the missed or cancelled appointment and the charge cannot be billed to my insurance. I understand that arrival on time for sessions is important and lateness past 10 minutes can result in a $5 charge.

_____ _____
Parent/Guardian Signature ***Date***

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JEWELS Pediatric Therapy Clinic-HIPAA Consent and Disclosure

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. We understand that his or her medical information is personal to you, and we are committed to protecting that information. As our client, we create medical records about your child's health, our care for him/her, and the services we provide for your child. By law, we are required to make sure that your child's protected health information is kept private.

By signing this form, you consent to our use and disclosure of protected health information about your child for treatment, payment and health care operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, _____, have read and agree to the HIPAA privacy practices.
Parent's Name: _____
Parent's Signature: _____ Date: _____

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Optional Credit Card Authorization Form

Payment is expected at the time of service. The patient is responsible for any deductible or co-payment. This form authorizes JEWELS Pediatric Therapy Center to charge your credit card for copayment or deductibles. This form is unnecessary if your insurance does not have a fee per session, a secondary insurance is applied, or you would like to pay individually at each session. Checks and cash are welcome.

I allow JEWELS Pediatric Therapy Clinic to bill my personal or Health Savings Account (HSA) credit card for co-pays, co-insurances, deductibles and balances at each of my child's visits.
Check the applicable ones below:
☐ Co-payment per session $_____
☐ Deductible amount due is $_____, we will collect $_____ per session until the deductible is met
☐ Co-insurance amount due is $ _____, we will collect $_____ per session which is an estimate of coinsurance due
☐ Please charge for any outstanding balances.
Your credit card information will stay on file will be and used to pay any outstanding balances. If outstanding balances are not paid within 60 days of statement, your credit card will be charged.
Please Circle One: VISA American Express MasterCard Other: _____
Name on Credit Card: _____
Credit card #: _____
Date of expiration: _____
CVV: _____ Address:_____
Date: _____ Signature: _____