MAINELY KIDZ PT
895 Portland Rd, Saco ME 04072
Ph (207) 439-5104 Fax (207) 571-8134
www.mainelykidzpt.com

Client Information Sheet

Today's Date_____

Client Name:_____ **Male/Female** **DOB:**_____
First, MI, Last **(Please circle)** **Month/Day/Year**

Mother's Name:_____ **Father's Name:**_____

Address:_____ **Address:**_____

_____ _____

_____ _____

Home Phone: _____ **Work:**_____ **Home Phone:** _____**Work:**_____
Cell Phone:_____ **Cell Phone:**_____
Email Address:_____ **Would you like to receive notifications from MKPT via email? Y/ N**
Would you like to receive email/text message reminders of your appointments? Y/N____Email ____Text
Do we have your permission to leave a message on your answering machine? Yes _____ No _____

Client's physician:_____ **Physician Phone/Fax:** _____
Physician Practice Name:_____

Emergency Contact: _____**Phone Number:** _____ **Relationship:** _____

Primary Insurance Information ***Secondary Insurance Information***

Policyholder's Name:_____ **Policyholder's Name:**_____

Insurance Carrier:_____ **Insurance Carrier:**_____

Certificate ID#:_____ **Certificate ID#:**_____

Group #:_____ **Group #:**_____

Policyholder's DOB:_____ **Policyholder's DOB:**_____

Mainecare #:_____ **Is this managed, or Primecare? Yes____ No____ Don't know____**

Referred By (check one): PCP_____ Other:_____

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Financial Agreement

Welcome to Mainely Kidz PT (MKPT). This financial agreement is intended to clarify the financial policies set forth by MKPT. We value our clients and their families, and we are committed to providing the highest level of care. Thank you for choosing Mainely Kidz PT for your therapy care.

Automatic Payment Agreement - Mainely Kidz PT requires an automatic payment agreement be completed by all clients utilizing commercial insurance coverage with no secondary insurance coverage, and client's utilizing MKPT prompt pay fee schedule. The automatic payment agreement along with MKPT weekly claims billing and reconciliation processes offers families the opportunity to pay out of pocket expenses identified by their insurer more frequently so that potentially large and possibly unexpected balances are not accumulated over time. Upon completion the automatic payment agreement will remain active until services are no longer necessary or upon any insurance changes that would nullify the need for the agreement to remain on file. Automatic payment agreements will become inactive once it has been determined that services are no longer required and/or upon confirmation that all claims have been processed and there is no client balance due. It is the responsibility of the client family to ensure that the credit card information provided with the automatic payment agreement remains current. MKPT must be notified immediately of any changes in account numbers and/or expiration dates.

I fully understand and agree to MKPT's Automatic Payment Agreement policy: _____
Initials

Copayments/Coinsurances - are due at the time of service. Copayment/coinsurance amounts may be paid via cash, check, or credit card on file.

I fully understand and agree to MKPT's Copayment/Coinsurance policy: _____
Initials

Prompt pay fees – Clients without insurance, or clients choosing not to utilize their insurance benefits, are required to utilize MKPT prompt pay fee schedule for services provided. Prompt pay fees are required to be paid in full at the time that services are rendered. Insurance will not be billed for these services. Prompt pay fees may be paid via cash, check, or credit card on file.

I fully understand and agree to MKPT's Prompt Pay Fee policy: _____
Initials

Deductibles - If eligibility information confirms a deductible exists in the insurance plan the deductible will not be charged at the time of the visit as it is difficult to obtain current deductible information at the time services are provided. Upon receipt of the explanation of benefits (EOB) from the insurer, any deductible balance noted will be charged at the patient's next office visit. If no future visits are scheduled the deductible amount due will be immediately charged to the credit card on file.

I fully understand and agree to MKPT's Deductible policy: _____
Initials

Client Account Balances –Client balances, including credit balances for active clients will be discussed at the next office visit. Client families will be notified by the MKPT front office of balance amount due or credit amount while at the visit. Client balances may be paid via cash, check, or credit card on file. Credit balances will automatically be applied to any outstanding balance due when applicable. Credit balances will be applied to an upcoming office visit(s) whenever possible or will be refunded within 30 business days. If no future visits are scheduled balances will be collected using the credit card on file. Client account balances are required to be paid in full within 90 days. Accounts not paid in full within the 90 day timeframe will be sent for further collections, to a collection agency or filed in small claims court. Any additional postage or fees for either collections or small claims services will be billed to the client/responsible party and no future balance statements will be generated.

I fully understand and agree to MKPT's Patient Account Balance policy: _____
Initials

Returned Check Fee - All returned checks will be subject to a $25 processing fee.

I fully understand and agree to MKPT's Returned Check Fee policy: _____
Initials

Assignment of Benefits – Your signature below confirms that you agree to assign all insurance benefits for services rendered, otherwise payable to you, to be paid directly to MKPT from Medicaid or private insurance. Your signature below also authorizes MKPT to release medical information to your insurance company, its agents or any third party for use in determining your benefits.

I fully understand and agree to MKPT's Assignment of Benefits policy: _____
Initials

Insurance Changes – MKPT requires immediate notification of new or additional insurance coverage. If MKPT is unable to confirm the new or additional insurance coverage prior to services being provided, the client family will be responsible for any balance due associated with those services. MKPT will not retroactively bill insurance for services previously provided. Client families may utilize MKPT prompt pay fee option if they would like to continue receiving services until eligibility is able to be confirmed. Client families must notify MKPT if they would like to utilize the prompt pay fee schedule PRIOR to services being provided.

I fully understand and agree to MKPT's Insurance Changes policy: _____
Initials

Out of Network Insurance Charges - Client families will be required to utilize MKPT prompt pay fee schedule for any out of network services. Prompt pay fees are required to be paid at the time services are provided via cash, check or credit card on file. Upon the family's request MKPT will provide a fee ticket containing specific service information to the client family following the completion of each office visit. Claims filing will be the responsibility of the client family. MKPT will not be responsible for obtaining any insurance authorization(s), or PCP referral(s) required from any out of network insurance carriers.

I fully understand and agree to MKPT's Out of Network Insurance Charges policy: _____
Initials

Cancellation/No Show Fees – as a courtesy only, MKPT will attempt to confirm your appointment prior to the date. Mainely Kidz cannot guarantee a reminder call/text/email. MKPT charges a fee of $25 for appointments missed or cancelled without 24 hours' notice. By signing this agreement you agree to pay such fee.

I fully understand and agree to MKPT's Cancellation/No Show Fee policy: _____
Initials

Your insurance policy is a contract between you and the insurance company and MKPT is not a party to that contract. It is your responsibility to understand the coverage and limitations of your insurance and you are ultimately responsible for unpaid balances and non-covered services.

I confirm that I have reviewed the information provided in this financial agreement and consider myself informed of MKPT financial policies. I understand that the terms outlined in this agreement are the policy of MKPT and that I may not revoke this agreement at any time.

_____
Patient Name

_____ _____
Signature of Responsible Party Date

_____
Printed Name of Responsible Party

_____ _____
Witness Date

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Designation of Individuals Who are Involved in Payment or Treatment Decisions

In order to comply with federal privacy laws, Mainely Kidz PT ("Clinic") may provide limited information to individuals who may be involved in treatment or payment decisions unless you object to sharing this information.

The Clinic requests that you list on this form the people you authorize to receive health information **(e.g. family members or others who accompany you to appointments or who call the Clinic on your behalf).** Please provide the full name(s) of these individuals in the lines below, the relationship to the patient, and whether they are involved in decisions related to treatment and/or payment. You do not need to list yourself if you are the patient or responsible party.

I authorize the Clinic to disclose information related to treatment or payment obligations to the people listed below.

Please enter the information requested and check the appropriate box to indicate whether the individual is involved in payment and/or treatment decisions.

Individual's Full Name (Please print)	**Relationship to Patient**	**Involved in Payment (Check if Yes)**	**Involved in Treatment (Check if Yes)**

This information will be presumed valid and the Clinic may rely on it until you have notified the Clinic in writing of any changes to this form. Notification of a change in the above information provided by you should be sent to Mainely Kidz PT, 895 Portland Rd, Saco, ME 04072.

_____ _____

Full Patient Name (printed) Legal Representative (printed) *if applicable*

_____ _____

Patient or Legal Representative (signature) Signature Date

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CLIENT CONSENT TO E-MAIL USAGE

Name of Client: _____ Date of Birth: _____

IMPORTANT INFORMATION ABOUT USE OF E-MAIL

Because e-mail is not a secure or confidential medium, we cannot guarantee that any e-mail that you may send to, or receive from us will remain confidential. While we consider your communications private and confidential and do not disseminate information about you without your permission, our administration reserves the right to monitor e-mail usage and so others might therefore see the text of your message. For this reason, we offer the following information to help you decide on the best method for communicating with us:

If you are in any way concerned about the contents of your email being read by someone other than the intended staff person, you might want to consider phoning or dropping by our office instead.

When we respond to e-mail, we will respond to the address from which it is sent. if you do not wish others who may have access to the e-mail account you are using to also have access to our response, please consider another means of contacting us.

While we check our email often during the regular office hours, you need to know that your e-mail message may not be received immediately. E-MAIL IS NOT RECOMMENDED FOR CONTACTING US IN AN EMERGENCY. if time is of a particular concern for you, please phone the office instead.

It is important for you to know that Internet messages, i.e. e-mail messages, are public communication and are not considered private. All communications, including text and images, can be subpoenaed and can be disclosed to law enforcement or other third parties without prior consent of the sender or the receiver.

Finally, our highest priority is to serve you, however, at times of high demand or problems with our computer system, we may not be able to respond quickly or effectively by e-mail.

We hope that the above information is helpful to you as you consider how to best communicate with our office. In honoring your confidentiality, we believe it is important that you understand the limitation of our use of e-mail and Internet technology at this time.

I hereby consent to communicate with Mainely Kidz PT employees regarding my services and treatment using e-mail. In granting this permission, I have read or have had read to me, and understand the information described above.

Signature of client or guardian: _____ Date: _____

Guardian/Client email address: _____

Mainely Kidz PT Staff Signature: _____ Date: _____

****

Revocation: I wish to revoke the consent given above with the understanding that my revocation will not affect anyone who takes action in reliance upon this Consent Form without notice of revocation.

_____ Date: _____
(Signature of _____client, _____ parent, _____ guardian)

Signature of Witness: _____ Date: _____

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Consent for Medical Photography

Patient Name: _____ Date: _____

_____ Check here if patient is under the age of 18 or is unable to provide consent.

I consent for medical photograph to be made of my child (or person for whom I am legal guardian). I understand that the information will be used in my/his/her medical record. By consenting to this medical photograph I understand that I will not receive payment from any party. Refusal to consent to photograph will in no way affect the medical care the patient will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

Jocelyn Nicoll
Administrative Assistant
Mainely Kidz PT

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

1) I agree to use of my/my child's image for medical records **ONLY**:

_____ _____
Signature of Patient/Parent/Legal Guardian **Witness Signature**

_____ _____
Printed Name **Relationship** **Printed Name**

2) I do not agree to use of my/my child's image for medical records **ONLY**:

_____ _____
Signature of Patient/Parent/Legal Guardian **Witness Signature**

_____ _____
Printed Name **Relationship** **Printed Name**

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MKPT AUTOMATIC PAYMENT PLAN

Mainely Kidz PT
895 Portland Rd
Saco, ME 04072

I Authorize Mainely Kidz PT to automatically charge my debit or credit card (Visa, MasterCard, Discover). This authorization is to remain in effect until I cancel it in writing.

If I do not have insurance, Mainely Kidz PT will charge my card for the full amount due for each office visit, for purchases I may make, and for any other costs incurred.

If I do have insurance, Mainely Kidz PT will charge my card for any required copay or coinsurance per office visit. When Mainely Kidz PT receives payment from my insurance, they may charge my card for any remaining balance. If the insurance claim is denied, Mainely Kidz PT may charge my card for any remaining balance.

I understand charges are normally processed on a timely basis (for example, within the same week as my office visit or purchase, or the same day an insurance payment is received) but I understand the processing may be delayed due to various reasons. I understand Mainely Kidz PT will not be notifying me before a charge is processed.

I understand if my card is declined, Mainely Kidz PT may continue to attempt the charge against my card on succeeding days. I understand that it is my responsibility to ensure that Mainely Kidz PT is notified of any changes in card status and to provide renewal information.

_____ _____
Patient Account Number Name of Patient

Print name as it appears on the card _____

Authorized Signature _____ Date _____

Home Telephone # _____ Work Telephone # _____

Home Address _____

Email Address _____

***PLEASE NOTE: Mainely Kidz will attempt to notify families of any outstanding balance while at the clinic for a regularly scheduled office visit prior to charging the card on file. However, for those clients no longer appearing on the clinic schedule the card on file will be charged automatically and without notice for any outstanding balance due. In this instance a receipt will be emailed/mailed to the address noted above once the payment has been processed. _____**
Initials

Please initial above showing that you have read and understand MKPT automatic payment process.

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Scheduling Information

Patient Name: _____ **Date:** _____

Please provide the following information to assist MKPT in the scheduling process.

Please note your availability for scheduling on the following chart:

Day	Check	Time(s)
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Please note any day(s) of the week that you are NOT available on the following chart:

Day	Check
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Mainely Kidz PT will do its best to schedule visits based on the availability that you have provided. However, this may not always be possible. We appreciate your assistance in providing this information and we look forward to working with you.

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Benefits Questionnaire

Therapy services are not necessarily covered in the same way that traditional medical services are covered by your insurer. Therefore, we have prepared an easy list of questions to ask when calling to verify benefits. Below is an informational form with the correct questions to ask regarding your individual therapy coverage and a place to record that information. Mainely Kidz PT highly encourages families to contact their insurer(s) to obtain this information prior to their initial visit:

Name of Insurance Company: _____
Address: _____
State: _____ Zip: _____ Telephone: _____
Employer: _____ Employee: _____
Relationship to patient: _____ Employee date of birth: _____
Subscribers SS# or ID#: _____
Group #: _____

Please record the name of the representative you speak with: _____
Date of call: _____

After giving the above information to your insurance representative please ask:

Do I have outpatient PT/OT/ST coverage? Yes No
If yes:
Lifetime Maximum? _____
Paid at what percentage? _____
Is there a deductible? _____ If yes, amount? _____
Is the deductible based on a calendar year or plan year? _____
Have I met any of the deductible to date? _____ If yes, amount? _____
Effective date of policy? _____
Do I have a copay? _____ If yes, amount? _____
Do I have a visit limit? _____
If yes, how many visits have I used to date? _____
Is my visit limit combined with any other benefit(s)? _____
Is a referral required for these services? _____
Is an authorization required for these services? _____

***Please keep for your records.**

Thank you