Mary Washington
PEDIATRIC THERAPY
a department of Mary Washington Hospital

200 Executive Center Parkway, Suite 106
Fredericksburg, VA 22401
Phone: 540.446.2654

mwhc.com

New Patient Intake

Today's Date:_____

Patient Name:_____ Date of Birth: _____/ _____ / _____

Patient Sex: ❑ Male ❑ Female

Person completing form: _____ Relationship to patient: _____

Who is accompanying the child to the evaluation? _____

Type of evaluation(s)

❑ Speech and Language

❑ Occupational Therapy *(needs prescription from physician)*

If this is for an OT evaluation, do you have the doctor's prescription needed for OT? ❑ yes ❑ no

If you do not have a doctor's script, is the doctor aware of the need for OT? ❑ yes ❑ no

If you do not have a script for OT, would you like us to contact the listed physician on your behalf? ❑ yes ❑ no

Patient Phone:_____

Patient Address: _____

City: _____ State:_____ ZIP Code: _____

Referred by:_____

Please list any medical diagnoses, if none enter N/A:_____

Who does the child live with? _____

Parent/Guardian Name: _____ Date of Birth: _____/ _____ / _____

Cell Phone: _____ Email: _____

Please let us know where we may leave a message regarding your appointments for your child:
❑ Home ❑ Work ❑ Cellular number

Pediatrician/Primary Care Physician:_____

Phone: _____ Fax Phone: _____

Emergency contact name: _____ Phone:_____
(please also add name to HIPAA form)

I give permission for Mary Washington Pediatric Therapy to provide treatment that may include, but not limited to diagnostic evaluations and procedures considered advisable in the diagnosis, treatment, and plan of care.

X:_____

I give permission for my child to participate in Mary Washington Pediatric Therapy services. I hereby release Mary Washington Pediatric Therapy principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Mary Washington Pediatric Therapy's services, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in Mary Washington Pediatric Therapy services. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/therapy equipment during services at Mary Washington Pediatric Therapy. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Mary Washington Pediatric Therapy in connection with their services from all liability as herein described.

X:_____

Acknowledgement, Release and Waiver of Liability – COVID-19

In Consideration for being permitted to enter Mary Washington Pediatric Therapy and participate in any therapy session:

I acknowledge that (i) novel coronavirus ("COVID-19") infections have been confirmed throughout the United States, including Virginia; (ii) COVID-19 is extremely contagious, and is believed to be spread by various methods, including person-to-person contact and contact with contaminated surfaces; and (iii) that it is believed that people who have COVID-19, but do not show symptoms, may be able to spread the virus as well.

I acknowledge that I am taking the risk that I will be exposed to infectious diseases including COVID-19 no matter what precautions are taken by Mary Washington Pediatric Therapy to reduce that risk.

I knowingly and freely assume all risks, known and unknown, arising from COVID-19, even those arising from the negligence of Mary Washington Pediatric Therapy its officers, agents, employees, instructors, and all affiliated persons or entities, and assume full responsibility for any and all participation.

I release, indemnify, and hold harmless Mary Washington Pediatric Therapy, its officers, agents, employees, instructors, and all affiliated persons or entities from liability for any illness, harm, injury or death, or loss or damage to person or property pertaining to COVID-19 and other contagious diseases and viruses whether arising from negligence or otherwise to the furthest extent permitted by law.

Waiver of Liability-COVID-19-As parent/legal guardian I understand and agree that this agreement is also made on behalf of my minor child and I represent and warrant that I have full authority to sign this agreement on behalf of such minor. Further, I hereby release, indemnify, and hold harmless Mary Washington Pediatric Therapy, its officers, agents, employees, instructors, and all affiliated persons or entities Institute from any and all liability incidents involving my minor child's participation including incidents of negligence.

X:_____

Parent/Legal Guardian: _____ Date of Birth: _____/ _____ / _____

Parent/Legal Guardian Signature:

X:_____

Child's Name: _____

Health Insurance Information

Do you have medical insurance? ❑ yes ❑ no

Financial Agreement

Services Fees (subject to change without notice):

Speech Therapy Evaluation: $400.00

Occupational Therapy Evaluation: $475.00

Feeding Evaluation: $400.00

Oromyofunctional Evaluation: $400.00

AAC Evaluation: $400.00

Speech/Feeding/MyoTherapy Treatment: ..... $250.00/30-min sessions

Occupational Therapy Treatment ..... $400/60 min; $300/45 min

Other fees (subject to change without notice):

No call No show fee for Speech Therapy: ..... $65.00 (not billable to insurance)

No call No show fee for Occupational Therapy: ..... $65.00 (not billable to insurance)

Court Fees for Witness Testimony or other court appearance: ..... $100/hour with 2-hour minimum (not billable to insurance) **Requires 7 days notice to appear**

All Refunds require 30 days to process

****Invoices that are not paid by the due date will have a $30.00 late fee added.**

At the time of service, co-treatments may require separate Payments and billing, including co-pays or coinsurance, for each service. Each co-treat is counted as a total of 2 visits (1 visit for ST, and I visit for OT). If your insurance company combines the number of visits per year to include both ST and OT services, this may affect the oyerall rate at which visits are utilized. The parent is responsible for keeping track of the remaining number of sessions available for treatment.

Acknowledgement of Attendance and Clinic Etiquette Policies

The clinicians will assist in helping you with activities to do in the home for the establishment and carryover of therapy targets. Consistent attendance and home practice of therapy homework is a critical part to my child's success. If a therapist has to be absent, your child will be scheduled with another one of our therapists to ensure the continuity of their care. Outside providers, such as ABA and others, must first contact and consult with the treating therapist prior to visiting to ensure the integrity of the sessions is maintained. The Attendance and Clinic Etiquette Policies are both online as well as in office. See the front office for more information.

I understand and agree to abide by the Attendance and Clinic Etiquette policies and procedures of Mary Washington Pediatric Therapy.

X:_____

Acknowledgement of Privacy Policy (HIPAA)

I have received a copy of the Privacy Policies (HIPAA) and understand my rights as well as the general policies and procedures of Mary Washington Pediatric Therapy. I hereby authorize use or disclosure of protected health information about my child as described in the HIPAA Policy.

X:_____

Communication Consent (Permission for Exchange of Medical Information (HIPAA))

I authorize Mary Washington Pediatric Therapy to release and communicate necessary and pertinent medical information to physician's, case manager's, and insurance companies as needed for my child. Approved information includes written documents and/or verbal discussion. Approved information may be given to, received from, and discussed with the following people directly related to my child's care: Please include Spouse, Pediatrician, Outside Providers (i.e. school therapists) as appropriate.

Individuals approved to share medical information *(please list full name and relationship to child)*:

_____

_____

_____

_____

***Please note that anyone that brings the child to therapy must be added to the communication consent (HIPAA) form in order for us to communicate any of your child's information, including therapy session updates and home exercises. Please list names of other people authorized to receive information about your child's care (i.e. grandparent, babysitter, caretaker)

**Email is another option to share medical information; however, it is not a secure form of medical record transmission and may be intercepted by third parties or transmitted to unintended parties. All email correspondence is printed and added to the patient file. Please indicate that you understand that it is not a secure form of communication and give consent for email transmission of your child's medical information?

Choose one:

❑ No, I prefer not to communicate any medical information via email Yes, I approve of email communication as necessary for medical information (enter approved email in box below)

❑ Yes, I understand that email communication is not secure I give consent for medical information be sent via email to the following preferred email address:

_____

I approve for Mary Washington Pediatric Therapy to communicate with individuals listed as indicated above.

X:_____

Patient Portal Consent

Mary Washington Pediatric Therapy now allows you to access to patient information in one easy-to-use location!

This form is intended to inform you of the risks and the conditions of participation in the Patient Portal, and to obtain your consent to and acceptance of these risks and conditions.

Purpose of the Patient Portal:

- View Upcoming Appointments
- Complete Needed Documents
- View Certain Billing and Healthcare Documentation
- Make Payments
- Access Teletherapy (upcoming)
- Teletherapy Sessions

The Patient Portal will not be used to diagnose or treat new health conditions or to provide treatment.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology, you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and

2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

While Mary Washington Pediatric Therapy uses reasonable efforts to maintain security and privacy, only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly let us know so we send you a password reset link.

Additionally, although Mary Washington Pediatric Therapy uses reasonable efforts to maintain the Patient Portal, the Patient Portal may experience defects or failures, including disruptions in service. Mary Washington Pediatric Therapy is not responsible for these defects or failures. Further, Mary Washington Pediatric Therapy does not keep backup data submitted to Patient Portal, and you are responsible for creating backups of any data or documents you submit through the Patient Portal.

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this Patient Portal User Agreement & Consent Form. I understand the risks associated with online communications between Mary Washington Pediatric Therapy and me, and consent to the conditions outlined herein. I understand and agree with the information that I have been provided and am aware I may opt out of joining the Patient Portal and not choose to disclose my email address. I further authorize Mary Washington Pediatric Therapy to upload my health information to and communicate with me regarding my health information through the Patient Portal.

Please indicate your choice:

❑ Yes, I wish to be added to the portal.

❑ No, I do not wish to be added to the portal.

I approve for Mary Washington Pediatric Therapy to communicate with individuals listed as indicated above.

X:_____

Parent/Legal Guardian Signature (Use your mouse or finger to draw your signature above)

Parent/Guardian Preferences

Consent for Photo/Video Release: I understand videos for feeding evaluations and feeding therapy will be taken for therapeutic purposes. For other therapy services, therapists may prefer to take a photo or video of a child in therapy (i.e. baseline data, having child see performance, progress comparisons). The photograph or video recorded sessions will be used for treatment, education, and training purposes only (i.e. treatment exercises, therapy progress, clinical supervision, in-service presentations). At no time will your child's full name be spoken on the video and your child's full identity will remain confidential.

❑ I give permission for my child to be photographed or video recorded for purposed listed above.

❑ I do not give permission for my child to be photographed or video recorded for purposed listed above.

Student Clinicians: At Fox Therapy Center, PLLC, we give back to the educational and professional community by allowing students and interns to learn at our facility. This means that a graduate or clinical student (intern) may observe treatments by shadowing the clinicians in our clinic, or work with patients with therapist present. Please indicate below if you would be willing to allow a student observe and/or work with your child. I give permission for students to be able to: ❑ Observe my child ❑ Work with my child ❑ Neither

I understand and agree to the above preferences,

X:_____