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4400 JENIFER ST NW
SUITE 280
WASHINGTON DC 20015
202.244.8089 OFFICE
202.244.8065 FAX
www.sensationalkids-therapy.com WEB

WELCOME!

Welcome to Sensational Kids Therapy! We look forward to working with you and your child and are pleased you have chosen Sensational Kids Therapy. We offer pediatric occupational and physical therapy and we look forward to working with your child's therapeutic and/or educational team.

Included in this packet are important procedures regarding communication, billing, and scheduling. In addition, you will find new patient forms. **Please complete, sign and send back all of the forms within 1 week of your child's first session.** Forms may be mailed, dropped off, or faxed to (202) 244-8065.

Sensational Kids Therapy is an out-of-network provider. However, we partner with a billing company to verify your insurance benefits and to submit your claims to your insurance company on your behalf. After the insurance claims process is complete and any insurance payments are applied to your account, statements are mailed and detail any balance due to Sensational Kids Therapy.

The goal of each therapist is to provide the best service possible for each client. To this end, continuous communication is important among parents and any other professionals working with your child. Please keep us informed of any changes related to your child, both positive and negative, to help us gain a fuller understanding of him/her.

We are located at 4400 Jenifer Street, NW. Our building entrance faces 44th Street and there is metered parking in front, as well as 2 hour zoned parking around the corner on Harrison Street. When you enter the building, go up a short staircase and take a left down the hallway where you will find our suite, #280. We are conveniently located within walking distance of the Friendship Heights Metro stop.

Thank you again for choosing Sensational Kids Therapy! We strive to provide you and your child a fun, play based atmosphere to help your child improve his/her function and independence.

Sincerely,

Shiraz Kashani MS, OTR/L & Lisa George MS, OTR/L
Directors

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CHECKLIST OF ITEMS TO COMPLETE AND RETURN TO SENSATIONAL KIDS THERAPY

Please complete the following forms included in this packet and return them to Sensational Kids Therapy prior to 48 hours before your child's first scheduled session. Also, please forward any prior evaluations or medical history.

Please mail the completed forms to the address below or fax the forms to (202) 244-8065

Sensational Kids Therapy
c/o Lisa George or Shiraz Kashani
4400 Jenifer St., NW
Suite 280
Washington, DC 20015

- ○ Emergency Information Form
- ○ Financial Policy and Agreement
- ○ Credit Card Authorization Form
- ○ Authorization for Treatment
- ○ Authorization for Release of Information
- ○ Notice of Privacy Practices Acknowledgment
- ○ Confidentiality Policy
- ○ Release for Educational and Teaching Purposes
- ○ Video/Photograph Release
- ○ COVID-19 Information

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EMERGENCY INFORMATION

Child _____ Birthdate_____ Phone(___)_____

Address_____ Email_____
_____

Parent Name (1) _____Work Phone(____)_____Cell_____

Parent Name (2) _____Work Phone(____)_____Cell_____

Child's School_____ School Phone(____)_____

Two persons to call if we cannot reach parents/caregiver in an emergency:

Name _____ Relationship _____ Phone (___)_____
Name _____ Relationship _____ Phone (___)_____

Pediatrician's Name _____ Phone (___)_____

Pediatrician's Address _____

Conditions Which May Require Immediate or Emergency Care
(i.e., diabetes, epilepsy, bee sting reactions, allergies, etc.)

1. _____ Treatment _____

2. _____Treatment _____

If your child is taking medication on a regular basis, please indicate name of the medication and the purpose of the medication as well as any other pertinent information below:

_____

Does your child wear glasses/corrective lenses? _____

If my child becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or above-named physician to give the emergency medical treatment required:

Hospital _____ Address _____

Caregiver's Name _____ Phone (___)_____

I give permission for the above named caregiver to pick up my child from Sensational Kid Therapy when my child's therapy is finished. In the event that another person will pick up my child, I will notify Sensational Kids Therapy.

Parent's Signature _____ Date _____

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AUTHORIZATION FOR TREATMENT

I, _____, acknowledge and agree to have my child, _____ participate in therapy services at Sensational Kids Therapy. I acknowledge that there is some risk inherent in the use of the therapy equipment. I hereby release Sensational Kids Therapy, its principal owners, therapists, employees, representatives, and all other individuals or organizations acting on behalf of Sensational Kids Therapy in connection with this program from any and all claims which I or my child may have arising from, resulting from, or in connection with my child's participation in therapy including, 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 equipment during the program. This agreement is signed for the purpose of fully and completing releasing, discharging, and indemnifying Sensational Kids Therapy, its principal owners, therapists, employees, representatives, and all other individuals or organizations acting on behalf of Sensational Kids Therapy, in connection with this program from all liability as herein described.

_____ _____

Signature Date

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Child's Name: _____ Date: _____

FINANCIAL POLICY AND AGREEMENT

We look forward to working with you and your child to meet your child's therapeutic needs. In that effort, we have developed a financial responsibility policy to avoid any misunderstanding and to ensure timely payment for therapy services.

__◉__ I am opting in to use the billing service. By signing and initialing this form, I am agreeing to the following process for the submission of insurance claims through our billing department. (Please initial all numbered items below).

__◯__ I am opting NOT to use the billing service. I am choosing to pay out-of-pocket for my child's occupational and/or physical therapy services. As a result, it is my responsibility to obtain any necessary authorizations prior to participating in an evaluation or therapy sessions and it is my responsibility to submit claims for each therapy session. If I choose to use the billing company in the future, the billing company will not be responsible for any claims prior to the start date of using their services. (Please skip to # 13 below).

All clients must sign the Client Financial Responsibility form prior to receiving therapeutic services.

Billing Services

1. Sensational Kids Therapy will submit your child's evaluation and therapy session charges to your insurance on your behalf. Please remember that Sensational Kids Therapy is out-of-network with all insurance plans.
   _____Parent Initials

2. Our billing department will verify your insurance benefits and explain them to you prior to your first appointment. **If they leave a message and ask you to return a call, it is important to call them back.**

They will also obtain any necessary authorizations unless your insurance plan requires the authorization to be requested by the primary physician or family. If you have questions, you can contact our billing department at (571) 481-2455.

_____ Parent Initials

3. Once your claim has processed, you will be billed for any balance due. If there is no insurance reimbursement or if you have no out-of-network benefits: the patient responsibility will be no more than $176 for an OT or PT session (4 units). Therapy sessions are billed in 15 minute units.

   We make every effort to collect full payment from your insurance company. If your claim cannot be resolved through your insurance within 90-days, the balance will be transferred to your responsibility under the self-pay rate mentioned. It is then your responsibility to resolve the denial with your insurance. If the issue is resolved and you require us to rebill the claim out or coordinate with you and your insurance, we are happy to do so.

   _____ Parent Initials

4. Charges for evaluations vary. A Sensational Kids therapist will discuss the testing and pricing with you prior to scheduling an evaluation After insurance processes your claim, you will receive a statement if there is a balance due and your credit card on file will be charged for that balance.

   _____Parent Initials

5. Sensational Kids Therapy's billing department will issue statements every 28 days if there is an outstanding balance due on your account. Once your statement has been mailed, you will have 5-7 days to call with any questions. Your credit card on file will then be charged for the balance due on the statement. The statement you receive is a notification of services only – please do not remit a check as your card on file will be processed in our system. We accept Visa, Master Card, and Discover. You can contact our billing department at (571) 481-2455 or you can email questions to billing@sensationalkids-therapy.com.

   _____Parent Initials

6. Families are responsible for updating insurance information with our billing department. Any delay in updating information may result in denied payment for services that are provided prior to receiving the updated information. Payment for denied services will be billed to you directly.

   _____Parent Initials

7. Sensational Kids Therapy is **unable** to submit to insurance for the following services. Our charges for these services are billed in 15-minute units at the same rate as therapy sessions ($44/unit for OT/PT).
   - School observations
   - School meetings
   - Consultation in the office or by phone
   - Additional written reports or letters requested by the parent/guardian

- Progress updates required by the insurance company for additional visits, medical reviews and authorizations (up to 60 minutes per report)
- Development of therapeutic materials or programs (amount of time will be agreed upon with parent/guardian prior to the delivery of service)

_____Parent Initials

Secondary Insurance

8. You MUST inform the practice if your child has more than one insurance policy. The practice will verify with both policies to confirm which policy is primary. This is critical to getting any necessary authorizations and having your claims process correctly.

   Please be aware that, if you have or decide to obtain secondary insurance, one plan will be primary for ALL claims. The determination of which plan is primary and whether any payment would be made by a secondary plan depends on the rules specified in each insurance plan.

   _____Parent Initials

9. The practice DOES NOT bill secondary insurance for you. You can use your primary insurance EOB/EOP to submit to your secondary insurance per your secondary insurance instructions.

   _____Parent Initials

10. If you do not notify the practice of more than one policy, you may end up being responsible for the cost of any services that are denied or processed incorrectly.

    _____Parent Initials

GAP Coverage

11. If you have Out of Network benefits, the practice WILL NOT file claims under GAP coverage. If you have out of network benefits and you still want to obtain and use GAP coverage, you will be responsible for filing your own claims and obtaining any required authorizations for service. When there are out of network benefits under your policy, GAP coverage creates a delay in claims processing that the practice cannot afford to manage.

    In this case, you will be billed directly for services and your credit card will be charged according to the balance due on your statement. You may use your billing statement to submit to insurance for reimbursement. Your insurance may also have its own forms to submit in addition to your billing statement.

    _____Parent Initials

12. If you DO NOT have out of network benefits under your policy (i.e. you have an HMO and are not allowed to go out of network) and you are able to obtain GAP coverage, the practice WILL file claims and follow them for you.

    _____Parent Initials

Out-of-Office Fee

13. An “Out of Office Fee” will be added to sessions that occur outside of the Sensational Kids Therapy clinic at $20 per session.
    _____Parent Initials

Late Pick-Up Fee

14. Since we are not able to supervise your child either before or after his/her treatment session, we ask that you remain with your child until the therapist is ready for him/her, as well as being present at the end of the session to pick up your child. We require parents to return to the waiting room 50 minutes from the start of their child’s session. If parents have not returned at the 55-minute mark, **a $15 late pick-up fee will be assessed.**
    _____Parent Initials

Tardiness, Cancellations and No-Shows

15. If you are 15 minutes (or more) late for your session, we cannot bill insurance for this time. We will submit charges to insurance for the time spent with your child while the late time will be billed to you directly.
    _____ Parent Initials

16. If your child is sick or unable to attend therapy, please contact your child’s therapist immediately to cancel and reschedule the session. Please do not bring your child to the office if he/she is sick. **Your child must be free from fever, vomiting/diarrhea, and on antibiotics as needed for 24 hours prior to his/her session.** Please note this policy is important to protect your child, other children, and staff.
    _____Parent Initials

17. **Please cancel within 24 hours prior to your child’s scheduled session or a “Cancellation” fee, billed at the full cost of the session, will be applied.** “Cancellation” fees cannot be submitted to insurance.

    Excessive cancellations will result in a loss of your reserved session time. Excessive cancellations include missing more than one session in a two month time frame for clients seen one time per week and two sessions for clients seen twice per week. Cancellations for federal holidays as well as your child’s winter and spring breaks (one week) will be excused. If excessive cancellations occur, you will be asked to schedule make-up sessions in order to keep your time slot.

    No charge will be applied for cancellations by a therapist.
    _____Parent Initials

18. If you fail to attend a scheduled therapy session without providing notice to your child's therapist, a "No-Show" fee, billed at $176 per session, will be applied to your next billing statement. "No-Show" charges cannot be submitted to insurance.
    _____Parent Initials

Weather Closures

19. **On snow days, therapy will be canceled when DC Public Schools are closed.** If DC Public Schools are not closed and there is a concern about weather affecting your child's therapy session, you must contact your child's therapist directly to discuss the situation.
    _____Parent Initials

Overdue Outstanding Balances

20. In the case of an outstanding balance, our billing department will attempt to contact you via phone and mail. If you are experiencing financial hardship, please contact us immediately so we can assist you with financial resolution on your child's account.
    _____Parent Initials

Administrative Fee for Statement Copies

21. Please keep your billing statements. An end of year comprehensive statement **will not** be generated for your tax/HSA/HRA submissions.

    It is time consuming and costly to reproduce the billing statements. A **$25.00 charge per billing statement** will be assessed to cover the time/cost to reproduce these statements if you make a request.
    _____Parent Initials

Acknowledgement of Sensational Kids Therapy Financial Policy and Agreement

22. Service charges are reviewed periodically. Sensational Kids Therapy reserves the right to adjust its charges when necessary. Thirty day advance written notice will be provided if service charges are going to be changed.
    _____Parent Initials

I acknowledge I have read and understand Sensational Kids Therapy's Financial Policy and agree to its terms.

Name of Parent/Legal Guardian _____

Signature _____

Date _____

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CREDIT CARD AUTHORIZATION

I direct Sensational Kids Therapy to use the following credit card to process payment. We accept **Visa, MasterCard, and Discover.**

Child's Name _____

CREDIT CARD

Name (as it appears on the card)		Card Number
Street Address (billing address associated with the card)		City
State	ZIP	Expiration Date
CVC Code	Email	

I ACKNOWLEDGE I HAVE READ SENSATIONAL KIDS THERAPY, LLC POLICIES AND PROCEDURES. I UNDERSTAND THE COST OF THE VARIOUS SERVICES, THE CANCELLATION AND MAKE-UP POLICY, AND THE BILLING PROCESS. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THE SERVICES PROVIDED TO MY CHILD.

Signature _____ Date _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give permission to Sensational Kids Therapy to discuss, release, or obtain information relative to my child's therapy from the following professionals (i.e., pediatrician, teacher(s), psychologist, speech and language therapist, physical therapist, developmental optometrist, etc):

(1) Pediatrician's Name _____

Address _____

_____

Phone (_____)_____

(2) Teacher(s) Name(s) _____

Address _____

_____

Phone (_____)_____

(3) Name(s) _____

Address _____

_____

Phone (_____)_____

(4) Name(s) _____

Address _____

_____

Phone (_____)_____

This will release **Sensational Kids Therapy** from all legal liability that may arise as a result of their compliance with my request.

Child's Name _____ Name of Parent/Legal Guardian _____

Signature _____ Date _____

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CONFIDENTIALITY POLICY

At Sensational Kids Therapy we are committed to maintaining client confidentiality. However, due to space constraints, we are unable to meet with each of our clients in a private room at the end of each session. Therefore, we use the waiting room to provide you with information about your child's therapy session and home recommendations. We understand that you may prefer an alternative arrangement. If so, please let us know and we will accommodate you. If you prefer, you can schedule a meeting or phone consult with your child's therapist every 1-2 months in place of one of your child's sessions or in addition to his/her session.

Child's Name: _____

Parent's Name: _____

_____ **I DO GIVE** permission for my child's therapist at Sensational Kids Therapy to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session.

_____ **I DO NOT GIVE** permission for my child's therapist at Sensational Kids Therapy to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session. I will schedule a meeting or phone consult with my child's therapist every 1-2 months to discuss my child's therapy sessions. I understand that I will be billed for this meeting and that I may schedule this meeting in lieu of one of my child's therapy sessions.

_____ I acknowledge that my child will be seen for therapy in a shared treatment space with other children. (Please initial)

_____ _____

Signature of Parent/Guardian Date

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NOTICE OF PRIVACY PRACTICES

Effective Date: August 23, 2011

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Facility Privacy Officials Lisa George or Shiraz Kashani at (202) 244-8089.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
The following categories describe how we may use and disclose your medical information.

For Treatment: We may use health information about you to provide you treatment or services. This means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

For Payment: We may use and disclose health information about your treatment and services for such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

For Health Care Operations: Members of our staff may use information in your health record for the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may disclose information to students for educational purposes. We may remove information that identifies you from this set of health information to protect your privacy.

We may contact you to remind you that you have an appointment; assess your satisfaction with our services; tell you about possible treatment alternatives; tell you about health-related benefits or services; and we may leave messages on your answering machine or voice mail regarding primary appointment reminders and billing/collections efforts.

Future Communications: We may contact you in the future via newsletters, mail outs, or other means regarding treatment options, health related information, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment, and healthcare operations. Therapists and caregivers may have access to protected

health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of your health information, including billing records.

Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our facility. Any request for an amendment must be send in writing to the Facility Privacy Official.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, or healthcare operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care (i.e., family member or friend). Any request for a restriction must be sent in writing to the Facility Privacy Official.

We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose related to payment of health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of at home or in a private room, rather than in the waiting room. The facility will grant requests for confidential communication at alternative locations and/or alternative means if the request is submitted in writing and the written request include a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with this facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in our facility.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide treatment and services
- Bill and collect payment from you, your insurance company, or a third party payer
- Conduct healthcare operations such as assess my care and outcomes and quality assessments

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of my rights and the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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RELEASE FOR EDUCATIONAL AND TEACHING PURPOSES

I, _____, authorize the therapists at Sensational Kids Therapy, LLC to allow my child, _____, to occasionally be observed during therapy sessions by fieldwork students/interns and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only.

_____ _____

Parent/Guardian Signature Date

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VIDEO/PHOTOGRAPH RELEASE

Due to the many advancements in technology, we have the benefit of capturing your child's time in the therapy gym via photographs and video. This allows us to use these types of media to show you what your child is doing when you are not able to attend therapy sessions. The photos and videos will only be shared with parents and caregivers of the below listed child either in the waiting room or via private email. Any such material is treated as highly confidential and will not be used for public viewing.

_____**I DO** give permission for my child's therapist to photograph or videotape my child during his/her therapy sessions. I understand that these images will only be shared between my child's therapist and me.

_____**I DO NOT** give permission for my child's therapist to photograph or videotape my child during his/her therapy sessions.

_____
Child's Name

_____ _____
Parent/Guardian Signature Date

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OCCUPATIONAL/PHYSICAL THERAPY & COVID-19

Child's Name: _____ Date of Birth: _____

Due to COVID-19, we are taking extra precautions to keep both our staff and patients safe. Parents/ guardians must sign this form prior to participating in therapy services. **Please note that we are now allowing children and therapists to share therapy space with others.** This will allow us increased flexibility with scheduling and provide opportunities for increased social interaction amongst our clients as appropriate.

Below are the continued precautions our office is taking to protect our staff and patients:

- Our waiting room is open. You are welcome to remain in our waiting room during your child's session or return at the 50-minute mark to pick them up and speak with your child's therapist.
- Each therapist and child will follow WHO protocol for hand washing before and after each session and hand sanitizer is available for use.
- Therapists will clean and disinfect all toys/equipment after each activity and/or session.
- **Masks are currently optional.** Please note that we reserve the right to reinstate the mask mandate at our office should circumstances change.
- Your child may not attend therapy for 5 days upon testing positive for Covid. We will continue to require masks for children and adults who have tested positive for Covid-19 (day 6-10) but are no longer required to isolate.
- We will follow CDC and DC Covid guidelines. However, due to the number of children who are immunocompromised, we may implement some protocols that exceed CDC guidelines to keep all our clients and staff as safe as possible.
- Regardless of whether or not your child has tested positive for Covid, **please remember that your child must be free of a fever and/or diarrhea and vomiting for <u>24 hours</u> before returning to therapy and any respiratory symptoms should be resolving**.
  *****Given the ever-changing circumstances surrounding Covid-19 throughout the United States, we reserve the right to modify protocols to keep our staff and clients safe*****

I agree to inform my child's therapist if my child has tested positive or someone in the home has tested positive for COVID-19 to allow her to make informed decisions about therapy attendance.

In the event that the therapist and/or patient fall ill following therapy sessions, neither party will be held liable or responsible for the illness, including COVID-19. Both parties agree not to come to therapy sessions if they feel ill in any way that would indicate they might be coming down with an illness.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____