Children's Neurotherapy Services, LLC. **Patient Registration Sheet**

Patient

Last Name:_____ First Name:_____ M.I.:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Physical Address (if different):_____

City:_____ State:_____ Zip Code:_____

Home Phone:(_____)_____ 2nd Phone:(_____)_____ Email: _____

Date of Birth:_____ Social Security Number:_____ Sex: **M** **F**

School Attending:_____ Grade:_____

Parent(s)/Guardian(s):

1) Last Name:_____ First Name:_____ M.I.:_____

Relationship to child:_____ Date of Birth:_____ Social Security #:_____

Address (if different):_____ City:_____ State:_____ Zip Code:_____

Employer:_____ Telephone: (_____)_____

2) Last Name:_____ First Name:_____ M.I.:_____

Relationship to child:_____ Date of Birth:_____ Social Security #:_____

Address (if different):_____ City:_____ State:_____ Zip Code:_____

Employer:_____ Telephone: (_____)_____

Nearest Relative NOT living with you:_____ Relationship:_____ Phone:_____

Acceptant of Financial Responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage. **Authorization to Release Information**: I hereby authorize Children's Neurotherapy Services, LLC. to release any information acquired in the course of my examination or treatment to insurance carriers, attorneys, or agencies involved in the payment of my account. **Assignment of Benefits**: I hereby authorize payment of medical benefits directly to Children's Neurotherapy Services, LLC.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Electronic Signature Agreement. By typing your name on the signature line, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. By selecting doing so you consent to be bound by this Agreement's terms and conditions. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise provide CNS Clinic. or in accessing or making any transaction regarding any agreement, acknowledgement, consent terms, disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), acceptance and agreement as if actually signed by you in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting contract between you and CNS Clinic. You also represent that you are authorized to enter into this Agreement for all persons who will be bound by the terms of this form. You further agree that each use of your E-Signature on CNS Clinic documents constitutes your agreement to be bound by the terms and conditions.

CNS Clinic -- Parent/Guardian Presence Agreement

Patient Name:_____**DOB:**_____

Policy

Observations of my child's treatment sessions are encouraged; however, due to limited space, only parents/guardians are allowed to be present during the session. All other family members should wait in the waiting area to lessen distraction.

PARENTS/CARE GIVERS MUST STAY AT THE CLINIC DURING THE TREATMENT SESSIONS!!

I understand that I am responsible for waiting with my child in the waiting room until the session begins. I am also responsible for waiting for my child during the therapy session, so that I am available to observe parts of my child's treatment when appropriate, and to be present should an emergency arise -- regardless of how unlikely. I understand that if I am absent from the premises I agree to allow the clinic staff to make decisions regarding medical treatment for my child in the event of an emergency and agree to accept responsibility for any emergency which might arise, whether I am present or absent. CNS Clinic staff members are **NOT** responsible for siblings and their supervision before, during or after treatment sessions.

I understand that if I do leave and don't return to pick up my child on time, that I will be charged the full treatment rate, in 15 minute segments, should my child require supervision by CNS Clinic staff beyond the scheduled appointment time.

I have read and agree to abide by the above policies.

Signature_____Print Name_____

Witness_____Date_____

INSURANCE VERIFICATION

We have the following insurance information for your account:

Patient Primary Plan Name _____

Patient Policy Number_____Patient Group Number _____

Policy Holder Name _ Policy Holder's Date of Birth _

Patient Secondary Plan Name _____

Patient Policy Number_____Patient Group Number _____

I have read and agree that the above information is correct. I also agree that my insurance benefits have been explained to me, but ultimately, I am responsible for the bill if insurance does not pay.

Signature_____Print Name _____

Witness_____Date _____

CNS Clinic -- Scheduling Agreement *(revised 9/13/2018)*

Patient Name:_____DOB:_____

Policy

I understand that if I am a new client to the CNS Clinic or am returning after an absence, I agree to have an initial consultation during the first two weeks of treatment with our therapist to review the evaluation and treatment plan with stated goals and objectives of treatment. I understand that after the evaluation, a Certified Occupational/Physical/Speech Therapist or Assistant may be treating my child.

I understand that the one-hour treatment session consists of direct treatment, parent consultation, note taking, and setting up the clinic to tailor the environment to the child's need for the treatment session.

I understand that additional time that is needed for consultation can be provided by ending a treatment session 5 to 10 minutes early, by scheduling a meeting with the therapist or by scheduling a phone consultation. If I desire a longer consultation, I may schedule calls or meetings with my child's therapist. A fee of in-depth phone consultation (more than 10 minutes) for myself or another professional involved in my child's case will be added to my bill at the treatment rate, pro-rated for the amount of time provided. If the school system or the insurance company pays for treatment, but does not authorize consultation time, this will be billed to me separately.

I understand that once a weekly treatment appointment schedule has been determined, this clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advance notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapist as well.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that notification of vacations or family obligations is expected at least two weeks prior to the expected absence. I understand that CNS Clinic may schedule make-up sessions for vacation time within the limitations of insurance criteria and physicians' orders.

I also understand and agree that if I miss three appointments without prior notification, CNS Clinic has the option to discharge my child and a new prescription from the Physician will be needed before services can resume. Excessive cancellations, even with 24 prior notification, may also result in your child being discharged and a prescription from the Physician will be needed before services can resume. To achieve maximum benefit from therapy, your child needs to be consistent with visits.

I understand that make-up sessions may occur with another therapist with this clinic.

I understand that I need to call to cancel my child’s appointment if he/she has or has had a fever of 100.5 degrees or higher in the last 24 hours, has a rash along with a fever, has crusty/red eyes, has head lice or has been vomiting or had diarrhea within the last 8 hours.

I understand that when our therapist is ill or is on vacation, the clinic will make every effort to provide a substitute therapist to ensure continuation of services. This clinic will attempt to schedule the therapist at our regularly scheduled appointment time. If this cannot occur, the clinic will provide alternative appointment times.

I understand that services will be terminated when the client has received the maximum benefit from therapy. The CNS Clinic therapist in conjunction with the child’s parent/guardian, physician, EISC and/or teachers will determine this.

CNS Clinic receives Physician's orders stating the frequency of therapy services. We must attempt to follow these orders. We also receive authorization through the insurance company based upon these orders. Canceling or not showing for scheduled appointments affects our abilities to follow the Physician's orders and also interferes with insurance authorization. We ask that you make every effort possible to show up on time for your appointments.

I have read and agree to abide by the above policies.

Signature_____Print Name_____

Witness_____Date_____

CNS Clinic Adverse Weather Conditions – Clients

Patient Name:_____DOB:_____

Policy

We will post closings/delays on WSOC Channel 9 and WBTV Channel 3. Call CNS before appointment time if weather is questionable. When we do close due to a blizzard, ice, or dangerous roads you may call to reschedule later in the day or later in the week. Parents who wish to cancel due to adverse weather will not be charged. Travel is at the discretion of the parent and clinic staff personnel.

CNS Clinic -- Fee Agreement

Policy

I understand that payment is due at time services are rendered, unless prior arrangements have been made. I understand that CNS Clinic will bill Medicaid and primary providers directly, but that I am responsible for deductible, co-payments, coinsurance and other charges not covered by my insurance provider at time services are rendered.

I understand that CNS Clinic, will, as a courtesy, file insurance for those patients who have out-of-network insurance coverage. However, I understand also that I am responsible for all co-payments, deductibles, coinsurance and other charges not covered by my insurance provider at the time services are rendered.

I understand that if my child receives services from the school system or another provider and services are provided on the same day as services at CNS, insurance will deny one of the claims and I will be responsible for payment of services rendered.

I understand that if my insurance carrier does not pay for services CNS Clinic will offer services at a personal private rate.

I understand that the portion due of my bill from the insurance carrier will be considered past due after 60 days of the date of therapy. I understand that after the 60th day of non-payment from my insurance provider, that CNS Clinic will send me a bill for the balance due, and that I will be responsible for paying that balance within 10 days of that bill. I also understand that it is my responsibility to contact my insurance provider should it not pay my bill.

I understand that CNS Clinic will attempt to cooperate with me in my efforts to pay my bill. However, in order for CNS Clinic to provide services to all of its clients, CNS Clinic holds me responsible for my bill and may use all legal means to collect debts owed to the clinic. There may be a 1.5% monthly interest fee added to my account for any past due balance.

We accept cash, checks, MasterCard and Visa.

A $20 fee will be charged for a returned check.

I have read and agree to abide by the above policies.

Signature_____Print Name_____

Witness_____Date_____

Electronic Signature Agreement. By typing your name on the signature line, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. By selecting doing so you consent to be bound by this Agreement's terms and conditions. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise provide CNS Clinic. or in accessing or making any transaction regarding any agreement, acknowledgement, consent terms, disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), acceptance and agreement as if actually signed by you in writing. You also agree that
no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting contract between you and CNS Clinic. You also represent that you are authorized to enter into this Agreement for all persons who will be bound by the terms of this form. You further agree that each use of your E-Signature on CNS Clinic documents constitutes your agreement to be bound by the terms and conditions.

CNS Clinic – Leaving Messages

Policy
By signing below, you hereby acknowledge that Children's Neurotherapy Services, LLC is authorized to leave information involving treatment or appointments on a voicemail or answering machine.

CNS Clinic – Email

Policy
If you would like to provide your email to receive updates on new patient services and special promotions, please include it below. We are committed to using reasonable means to maintain the security and confidentiality of your email address. However, please note there are risks associated with email communication. We cannot guarantee protection and you are hereby agreeing to indemnify and hold us harmless for any losses, expenses, damages or cost that may result. At this time at our practice, email is not used for staff or therapist correspondence. We will not sell your information. If you ever wish to be removed, please call our office at 828-212-0256.

Email address: _____

CNS Clinic – Photography/Videography

Policy
I, give my consent for my child, _____ (Parent or Legal Guardian)
(Client Name)

to be photographed/video-graphed by, or for the purposes of Children's Neurotherapy Services for clinical education, documentation of progress or marketing. I understand that this photographic/video-graphic record will not identify my child by surname for purposes other than his or her medical record.

I understand that I may revoke this agreement at any time without consequence to my child's therapy program, and that I may request copies of such photographic/video-graphic documents at my own expense.

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Witness Date

Electronic Signature Agreement. By typing your name on the signature line, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. By selecting doing so you consent to be bound by this Agreement's terms and conditions. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise provide CNS Clinic. or in accessing or making any transaction regarding any agreement, acknowledgement, consent terms, disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), acceptance and agreement as if actually signed by you in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting contract between you and CNS Clinic. You also represent that you are authorized to enter into this Agreement for all persons who will be bound by the terms of this form. You further agree that each use of your E-Signature on CNS Clinic documents constitutes your agreement to be bound by the terms and conditions.

CHILDREN'S NEUROTHERAPY SERVICES, LLC **CNS Clinic**

1087 13th Street SE, Hickory, NC 28602 **OFFICE** (828) 267-1688 **FAX** (828) 267-1690
4012 Hickory Blvd, Granite Falls, NC 28630 **OFFICE** (828) 212-0256 **FAX** (828) 212-1433

Patient's Name:_____

If you are interested in receiving a copy of the HIPAA policy, we will be glad to make you a copy. Otherwise, to save paper, we have it framed and on the wall for your review.

I acknowledge that I have been informed of the HIPAA Privacy Policy that is mounted at the office for us to read and have been offered a copy of this policy.

_____ _____
Parent/Guardian Signature Date

Due to privacy policy, we are unable to release information to anyone other than the child's guardian/parent. If your child will be brought to therapy by a grandparent, friend, caregiver, etc. and you want us to share information with them, please list their names below. Also, please list any doctor's, equipment vendors, school systems, therapists, etc. with which we may share information.

I agree that information regarding my child's care may be released to/received from the following people/agencies:

Children's Neurotherapy Services _____ _____

_____ _____

_____ _____

_____ _____
Guardian's Signature Date

Please list below anyone who may be present during therapy such as a grandparent, friend, caregiver, etc. The therapist will need to be able to speak with this person about your child's current therapy session.

I understand that the persons listed below may be present during my child's therapy and will be privy to information concerning that current therapy session.

_____ _____

_____ _____

_____ _____
Guardian's Signature Date

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CHILDREN'S NEUROTHERAPY SERVICES, LLC
CNS Clinic
4012 Hickory Blvd, Granite Falls, NC 28630 **OFFICE** (828) 212-0256 **FAX** (828) 212-1433

Highlights of Policies and Procedures

- **Parent/Caregiver must stay @ CNS during treatment sessions.**
- Upon arriving, stop by the front office to verify your child's next appointment, pay your co-pay and verify insurance information. Verification of eligibility for Medicaid services will occur at the beginning of **every** month.
- If your insurance company does not pay for services rendered, for whatever reason, you will be responsible for payment of our private rate.
- We will need a copy of your insurance card every year and during the year if anything changes.
- **Please call to cancel your child's appointment if he/she has or has had a fever of 100.5 degrees or higher in the last 24 hours, has a rash along with a fever, has crusty/red eyes, has head lice or has been vomiting or had diarrhea within the last 8 hours.**
- We attempt to schedule a make-up appointment within 2 weeks if possible for any missed or cancelled appointments.
- After three "No Show" appointments or excessive cancellations your child may be discharged from CNS Clinic.
- We ask for your patience as we attempt to determine an appointment at the same time each week that will work with your schedule. It may take a couple weeks to accomplish this.
- A different therapist may need to treat your child for various reasons (therapist out, make-up visit, etc.).
- In order to receive maximum benefit, it is very important that your child attends their therapy appointments.
- In case of bad weather, watch WSOC Channel 9 or WBTV Channel 3 for closing or delay information or call CNS clinic to find out if we will be open.
- Smoking is prohibited anywhere on the premises of CNS Clinic.
- **I understand that if my child receives services from the school system or another provider and services are provided on the same day as services at CNS, insurance will deny one of the claims and I will be responsible for payment of services rendered.**

If your child has an IEP at school, we need an updated copy ASAP. Medicaid requires this!

Acknowledgement of Review of Children's Neurotherapy Services, LLC Policies and Procedures: I hereby acknowledge that I have reviewed and agree to information contained in Highlights of Policies and Procedures: including scheduling agreement, parent/guardian presence agreement, adverse weather conditions policy and fee agreement.

_____ _____

Signature of Parent or Legal Guardian Date

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CNS Clinic
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PARENT COPY