ABSOLUTE Pediatric THERAPY

OFFICE POLICIES

LEGAL GUARDIANS MUST ACCOMPANY CHILD TO ALL APPOINTMENTS.
IF YOU ARE NOT THE BIOLOGICAL PARENT THEN YOU MUST BRING PROOF OF CUSTODY.

Please bring registration with you to the patients' first appointment. Do not send to the office.
We welcome you to the office and appreciate the opportunity to provide you with our services. To better serve you, we have established certain guidelines that should increase efficiency. Please review this information and feel free to ask any questions at your appointment.

OFFICE HOURS: Our office staff is available to receive your calls Monday – Friday, 8:00 am to 5:00 pm. The number listed is to reach our staff. (479) 250-4355.

AFTER HOURS CALLS: In case of an emergency after hours, please call (479) 271-3298.

APPOINTMENTS: If you need to change or cancel your appointment, please give at least 24 hours prior notice. NOTE: Failure to give this notice will result in your being financially responsible for the appointment. If a first appointment is missed with no explanation this office reserves the right to refuse to reschedule. If two appointments are either cancelled without 24 hour notice or without any notice, we will be unable to schedule further appointments but will assist in finding alternative coverage.

INSURANCE: **Please let our office know immediately if you have any changes in your insurance company, policy, billing, subscriber, etc. If you have a SECONDARY INSURANCE the office must know this information BEFORE THE FIRST APPOINTMENT. Please bring copies of your insurance card(s) or have receptionist make copies.**

Failure to keep our office informed of any insurance changes may result in your being financially responsible for your appointments.

ADULT SUPERVISION: **Due to financial constraints and issues of liability, we are unable to provide supervision for patients or their siblings during office visits. Every family is required to make arrangements to provide appropriate adult supervision during appointment times.**

Patient's Name: _____

_____ _____
Parent/Legal Guardian Signature Date

Revised 11/2017

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Payment Policy

It is the policy of Absolute Pediatrics Therapy to collect payment at the time of service. If we will be filing insurance and the deductible has been met, we ask that you simply pay the co-payment required at the time of service.

Patient /Legal Guardian Date

Staff Signature Date

Revised 11/2017

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MISSED APPOINTMENT POLICY

Because we hold the scheduled appointment time for you only, we must have 24 hour notice for cancellation. Unless it is a true emergency, you will be charged $40.00 (intake/therapy appointment) or $250.00 (psychological evaluation appointment).

To avoid any interruptions in your treatment you must not miss 2 scheduled appointments consecutively. Should this occur your next appointments would be scheduled at the end of the provider's waiting list.

This policy is to allow for people to be seen in a timely manner and free up appointment times that would be available for the provider to see other clients.

Thank you for your cooperation.

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Staff Member Signature Date

Rev. 11/2017

ABSOLUTE Pediatric THERAPY

Patient / Family Rights

Patient Name: _____ **DOB:** _____

1. You have the right to be treated with dignity and respect, as an individual who has person needs, feelings, and preferences.
2. You have the right to privacy in your treatment, in your care and in the fulfillment of your personal needs, and of protected health information.
3. You have the right to be informed of services available to you in Absolute Pediatric Therapy (APT) and of any charges for those services.
4. You have the right to be informed of your rights as a client and of all rules and regulations governing your conduct as a client in these facilities.
5. You have the right to know about your physical condition unless your provider, for medical reasons, chooses not to inform you, and so indicates in your records. You have the right to participate in the development of your treatment plan.
6. You have the right to receive information necessary to give informed consent prior to the start of any procedure and/or treatment.
7. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of your choices.
8. You have the right to voice opinions, recommendations, complaints, and grievances in relation to and your rights, without fear of restraint, interference, coercion, discrimination, or reprisal.
9. You have the right to be free from physical, chemical and mental abuse.
10. You have the right to confidential treatment of your person and medical records. Information from these sources will not be released without your prior consent, except in an emergency, or as required by law, or under third party payment contract. Absolute Pediatric Therapy utilizes electronic medical records (EMR) in compliance with HIPPA regulations.
11. You have the right to be assessed for pain and have evaluation and management of pain if indicated.
12. You have the right to file a complaint if you feel you have been discriminated against because of race, color, sex, religion, national origin, or disability.
13. You have the right to request the opinion of a consultant at your expense or to request an in-house review of the individual treatment plan, as provided in specific procedures of the facility.

ABSOLUTE Pediatric THERAPY

Patient / Family Responsibilities

The safety of health care delivery is enhanced by the involvement of the patient and/or family, as appropriate to his/her condition, as a partner in the health care process. Absolute Pediatric Therapy has identified the following patient and family responsibilities and educates the patient and/or family about these responsibilities during the admission process and as needed thereafter.

Responsibilities include at least the following:

1. **Providing information**

   - The patient and/or family are responsible for providing, to the best of their knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications, and other matters relating to the patient's health.

   - The patient and family are responsible for reporting perceived risks in their care and unexpected changes in the patient' condition.

2. **Asking questions:**

   - Patients and/or family are responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do.

3. **Following instructions:**

   - The patient and family are responsible for following the care, service, or treatment plan developed. Further, patient and family are responsible for following the program rules and guidelines. They should express any concerns they have about their ability to follow and comply with the proposed care plan of course treatment. Every effort is made to adapt the plan to the patient's specific needs and limitations.

4. **Accepting consequences:**

   - The patient and family are responsible for the outcomes if they do not follow the care or treatment plan.

5. **Following rules and regulations:**

   - The patient and family are responsible for following the rules and regulations concerning patient care and conduct. This includes helping control noise, and disturbances, following smoking policies and respecting others.

6. **Showing respect and consideration:**

   - Patients and families are responsible for being considerate of Absolute Pediatric Therapy personnel and property and other patients, their family members, and their personal property.

7. **Meeting financial commitments:**

   - The patient and family are responsible for promptly meeting any financial obligation agreed to with Absolute Pediatric Therapy.

8. Legal issues:

- Subpoenas are to be served in person, preferably at least a week in advance, but no later than 72 hours in advance. Any court appearances or legal documentation are subject to fees.

Patient/Legal Guardian Signature	Relationship	Date

Witness Signature	Date/Time