ODYSSEY
PEDIATRIC THERAPY SPECIALISTS

208-910-2360
1031 W. Sanetta St.
Nampa, ID 83651
odysseytherapies.com

Welcome to Odyssey Pediatric Therapy Specialists!

Odyssey Pediatric Therapy Specialists is the personalized and family centric therapy clinic you have been looking for! We know that a child's development is a journey and we want to be a part of it by helping your child and family grow and develop using natural therapy experiences in a fun and exciting environment. Our commitment is to create a consistent and purposeful experience by involving your child and family every step of the way.

Included in this packet you will find the paperwork necessary to begin your child's therapeutic journey. Please see the below checklist of the required forms and additional items for your child's first appointment.

NEEDED FORMS

- ☐ New Patient Pediatric Therapies Intake Form
- ☐ Insurance Information & Credit Card Authorization Form
- ☐ Financial Responsibility & Billing Procedures Form
- ☐ Authorization for Treatment Form
- ☐ Authorization for Release of Information
- ☐ Our Attendance Policy
- ☐ Teletherapy Consent
- ☐ HIPAA Policy and Consent to Consult
- ☐ Acknowledgment of Receipt of Privacy Practices

NEEDED ITEMS

- ☐ Parent/Legal Guardian License/Identification Card
- ☐ Insurance Card(s) regarding coverage of child
- ☐ Copy of Custody Paperwork (if applicable)
- ☐ Copy of IEP/504 (if applicable)
- ☐ Any pertinent medical records

Completed paperwork can also be emailed to our office at **info@odysseytherapies.com**.

Thank you so much for choosing Odyssey Pediatric Therapy Specialists. We look forward to starting this journey with you!

Sincerely,

Odyssey Pediatric Therapy Specialists

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New Patient Pediatric Therapies Intake Form

Child Information

Child's Name:_____ Date of Birth: _____

Age:_____ Gender: _____ Primary language spoken in the home: _____

What therapy services are you seeking for your child and why? _____

_____

_____

Legal Guardian #1: _____ Date of Birth: _____

Relationship to Child: _____ Occupation: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Okay to leave a voice message? ▢ YES ▢ NO

Physical Address: _____

Mailing Address: _____ City: ____ State: ____ Zip: _____

Email Address: _____

Occupation: _____ Employer: _____

Legal Guardian #2: _____ Date of Birth: _____

Relationship to Child: _____ Occupation: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Okay to leave a voice message? ▢ YES ▢ NO

Physical Address: _____

Mailing Address: _____ City: ____ State: ____ Zip: _____

Email Address: _____

Occupation: _____ Employer: _____

Who does the child live with? _____

Who has custody of the child? _____

*If there is custody paperwork regarding the child, please submit a copy to our office, **prior** to services.*

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Emergency Contact Information

Name: _____ Phone Number: _____

Relationship to Client: _____

Emergency Medical Release

In the event of a medical emergency, as the legal guardian of _____ (child's name), I give my consent for Odyssey Pediatric Therapy Specialists to contact emergency personnel.

_____ _____

Parent/Legal Guardian Signature Date

Child Medical & Developmental History

Medical History

Primary Care Physician: _____

Location: _____ Phone Number: _____

Please list all diagnoses and relevant information about the child's medical history:

_____

_____

All prescription drugs, over the counter medications, vitamins, and homeopathic medications:

_____

_____

All known allergies and their reactions: _____

_____

Prenatal and Birth History

During pregnancy and/or labor did the child's mother experience:

▢ hemorrhaging ▢ high blood pressure ▢ drug use ▢ smoking ▢ alcohol use

▢ infections ▢ other:_____

Was the child born premature? ▢ YES ▢ NO If 'YES' how early? _____ weeks

How was the child born? ▢ Vaginally ▢ C-Section

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Birth weight: _____ pounds _____ ounces

Were there any complications during labor or delivery birth? ▢ YES ▢ NO If 'YES' please explain: _____

Developmental History

Did the child reach all their developmental milestones at the appropriate ages? (i.e. sitting, crawling, walking, talking, potty training, etc.) ▢ YES ▢ NO If 'NO' please explain:

_____

Family History

Has anyone in the child's family been diagnosed with any relevant conditions that might also affect the child? ▢ YES ▢ NO If 'YES' please explain: _____

_____

Additional Therapies

Please list any other therapies your child is receiving (i.e. type, frequency, etc.): _____

_____

_____

Child's Education

Grade: _____ Name of School: _____

Does your child have, or has previously had, an Individualized Education Plan "IEP" or a 504? ▢ YES ▢ NO If 'YES' please describe what services/accommodations your child receives, or did receive, at school: _____

_____

_____

Additional Information

Is there anything else you would like us to know? _____

_____

_____

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Insurance Information & Credit Card Authorization Form

Primary Insurance	
Group Number	
Policy Number	
Insured's Name	
Insured's DOB	

Secondary Insurance	
Group Number	
Policy Number	
Insured's Name	
Insured's DOB	

****Please provide a copy of all pertinent insurance/Medicaid cards.****

Guarantor Credit Card Information

Card Type: ▢ MasterCard ▢ VISA ▢ Discover ▢ AMEX ▢ Other_____

Cardholder Name (as shown on card): _____

Card Number: _____ Expiration Date (mm/yy): _____

CVV Code _____ Cardholder ZIP Code: _____

Copay/Coinsurance amount $_____

I, _____, give permission to Odyssey Pediatric Therapy Specialists to charge my credit card on behalf of services provided. Services not covered by insurance are deemed my responsibility and will be given an out-of-pocket rate. Also, I understand that my credit card information will be safely and securely held on file for future or recurring charges.

_____ _____

Guarantor Signature Date

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Financial Responsibility & Billing Procedures Form

Odyssey Pediatric Therapy Specialists will help you estimate your cost per visit. Costs vary based on procedures performed, treatment duration and contractual agreements with insurance companies. Your estimated share or co-pay is due at the time of each visit. This also applies to those subject to Medicaid copays. If this is not feasible, you may arrange a payment plan.

You will receive a bill once a month. Because we are often waiting on payment and contractual adjustments from your insurance, the amount due on your bill will only reflect the treatments that have been addressed by your insurance. It will separately show charges that are pending insurance responses. If your bill reaches an excess of $300. Services will be placed on hold until payment is made to drop the bill below the $300 ceiling. A hold on your child's therapy schedule will be maintained for 2-weeks then your child will be placed on a waitlist if the bill is not paid.

To avoid late fees, you agree to pay 25% of the bill or $50 (whichever is greater). If this is not feasible, you can still avoid late fees by setting up a payment plan with our billing department. If the minimum amount due is not paid or you have not arranged a payment plan, your account will be charged a late fee of 25% of what is due (i.e. a $50 bill would have an additional charge of $12.50 if not paid by due date).

In the event that payment is not received two months in a row, your account will be turned over to a collection agency.

If any payment is made directly to you from your insurance company for services billed by us, you agree to promptly assign or endorse such payment to Odyssey Pediatric Therapy Specialists.

As the parent/legal guardian of the client receiving service, I _____ have read and understand the following:

- Odyssey Pediatric Therapy Specialists will bill insurance solely as a courtesy.
- Coverage Information provided to me by Odyssey Pediatric Therapy Specialists comes from information obtained from my insurance based on the information I provided. This information is not a guarantee of payment and there is a possibility that this information is not accurate.
- It is ultimately my responsibility to know and understand my own insurance benefits and coverage.
- I agree that I am responsible for payment of services even if my insurance denies payment.

I understand and agree that if I fail to make regular payments as described above, I will be responsible for all costs of collecting monies owed, including late fees, and collection agency fees.

I have read, understand and agree to the above conditions. I understand my full responsibility for the payment of my account.

_____ _____
Parent / Legal Guardian Signature Date

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Authorization For Treatment Form

I authorize the staff of Odyssey Pediatric Therapy Specialists to:

- Administer and perform those treatments that have been prescribed by my child's physician.
- Release pertinent medical information to my child's physician, referring agency, or insurer and others as may be required.
- Request and obtain medical information from my child's physician and other health care professionals as necessary to provide quality therapy services.

_____ _____
Child's Printed Name Date of Birth

_____
Parent / Legal Guardian Printed Name

_____ _____
Parent / Legal Guardian Signature Date

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Authorization for Release of Information

I, _____ , authorize Odyssey Pediatric Therapy Specialists to discuss and exchange, in verbal or written form, any relevant information to my child's treatment with the person, or any person(s) or staff of the institution, named below.

_____
Name of Individual and/or Institution Name

_____
Address

_____ _____
Phone Number Fax Number

For the following reason(s):
____ Therapy Evaluation/Progress Report
____ Medical Records
____ Coordination of Care
____ Other: _____

You may revoke this consent at any time. Unless otherwise revoked or renewed, this consent is in effect for one year from the date of the last session. This consent is subject to all conditions outlined in the Office Policies & Consent to Psychotherapy Services.

_____ _____
Parent / Legal Guardian Signature Date

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Our Attendance Policy

Each child has their own individual and specific therapy goals and needs. Due to time and insurance constraints, most kids are scheduled at very conservative frequencies. At these low intervals of treatment, it becomes imperative that caregivers make every possible effort to have their child at all scheduled appointments. When a child's scheduled appointment time is missed, it has an impact on many levels. The child misses vital therapeutic treatments, it jeopardizes the therapist's valuable time, and it is a disservice to those on our wait-list who are willing and able to make therapy a priority. In fairness to everyone, we strictly enforce our attendance policy.

ATTENDANCE TO ALL SCHEDULED VISITS IS EXPECTED

- Cancellations made less than 24 hours in advance, or failure to appear ("no-show"), will be subject to a $40 fee required to be paid at the next treatment session
- Arrivals to appointments 15-minutes or later than scheduled time are subject to the cancellation/no-show fee even if the child is treated for the remaining time available
- Efforts to reschedule are encouraged if there is availability
- Re-schedules should be made in good faith in regards to patient availability/transport.
- Cancellation of a reschedule will continue to be subject to the $40 fee

If the above conditions are not met the $40 fee will be charged to the card on file one week after the missed appointment or added to the next monthly billing statement.

If your child's therapist is absent for vacation/illness it will not affect your child's attendance and you will not be billed the $40 fee. However, you are still expected to attend your other therapy sessions, even if they are back-to-back sessions.

When monitoring attendance, family emergencies, serious medical conditions, and surgeries will be considered. Below are a list of reasons to cancel without the $40 fee assessed:

- **Illness:** Specifically, a fever over 100°, vomiting, diarrhea, unknown rash, onset of cold, hospitalization & doctor-specific reasons.
- **Medical Procedures:** Please advise us as soon as you are aware of a conflict so we can reschedule that appointment.
- **Unforeseen Family Emergencies**
- **Vacation:** We require a 2 day notice on any scheduled vacations. Any vacation scheduled longer than 2 weeks may result in forfeiting any reserved time slots. Please discuss this with individual provider(s) if you are planning a long vacation.
- **Other:** All reasonable exceptions will be considered on a case by case basis.

I have read, understand, and agree to the above conditions.

_____ _____

Parent / Legal Guardian Signature Date

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Teletherapy Consent

For continuity of care, it is important, and ***expected*** that your child attend every session in-person. However, in the event that a session needs to be missed and rescheduling is not an option, the $40 cancellation fee can be avoided if caregiver and child are able to attend a brief virtual visit to review home programming and plan-of-care at time of service. In order to ensure that a smooth teletherapy session can occur, please review and complete this form.

With regards to teletherapy appointments, I understand that it can include treatment using interactive audio, video, or data communications. As such, I understand that I am responsible for:

1. Ensuring access to the necessary computer, telecommunications equipment and internet access for the teletherapy session
2. The information security on my computer
3. Arranging a location with sufficient lighting and privacy that is free from distractions

I have the right to withhold or withdraw my consent at any time, but the $40 cancellation fee may still be billed should my child miss their appointment time (either virtual or in-person) without proper rescheduling.

I have read, understand and agree to the above information.

_____ _____
Child's Printed Name Date of Birth

.

_____ _____
Parent / Legal Guardian Signature Date

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HIPAA Policy and Consent to Consult

I hereby authorize Odyssey Pediatric Therapy Specialists and its affiliates, its employees and agents, the ability to send me electronic communication containing my child's personal treatment and health information maintained (such as information relating to the diagnosis, treatment, claims payment, and services provided or to be provided to my child and which identifies my name or my child's name, address, Member ID number, payment arrangements and balance information) except the following information (please describe information not to be disclosed, if any): _____
for the purpose of helping me to resolve claims, or health benefit coverage issues, and the purpose of communication regarding plan of care.

I also allow the Odyssey Pediatric Therapy Specialists staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of the child.

I understand that the electronic communication will be sent via an unsecure/unencrypted email network. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid for one year from the date listed below for one year.

I understand that I have a right to revoke this authorization by providing written notice to Odyssey Pediatric Therapy Specialists. However, this authorization may not be revoked if Odyssey Pediatric Therapy Specialists, its employees or agents have taken action on this authorization prior to receiving my written notice.

I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my child's eligibility for benefits or enrollment or payment for or coverage of services.

_____ _____
Parent / Legal Guardian Signature Date

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Notice of Privacy and Confidentiality Practices Acknowledgment

This notice describes how information about you may be used and disclosed and how you can get access to this information.

We are required by law to maintain the privacy of your health information and to give you notice of our legal duties and privacy practices with respect to your protected health information. This Notice summarizes our duties and your right concerning your protected health information. Our duties and your rights are set forth more fully in 45 CFR part 164. We are required to abide by the
terms or our Notice that is currently in effect.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION
Each time you visit Odyssey Pediatric Therapy Specialists Clinic a record of your visit is made. Your therapy records include your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. Your physical therapy records are used for:

· a basis for planning your care and treatment
· a means of communication among the many health professionals who contribute to your care
· a legal document describing the care you received
· a means by which you or a third-party payer can verify that services billed were actually provided
· a tool in educating health professionals
· a source of data for medical research
· a source of data for our planning and marketing
· a source to review for quality assurance of future patients.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS
Although your health record is the physical property of Odyssey Pediatric Therapy Specialists, the information belongs to
you. You have the right to:

· obtain a paper copy of this Notice of Privacy Policies upon request
· inspect and copy your health record as provided for in 45 CFR 164.524
· amend your health record as provided in 45 CFR 164.528
· obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
· request communications of your health information by alternative means or at alternative locations
· request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
· revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES
Odyssey Pediatric Therapy Specialists is required to:
· maintain the privacy of your health information
· provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
· abide by the terms of this notice
· notify you if we are unable to agree to a requested restriction
· accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

CHANGES TO THIS JOINT NOTICE
We reserve the right to change the terms of our Notice of Privacy Practices at any time, and to make the new Notice provisions effective for all protected health information that we maintain. If we materially change our privacy practices, we will prepare a new Notice of Privacy Practices, which shall be effective for all protected health
information that we maintain. We will post a copy of the current Notice in our clinic and on our website. You may also obtain a copy of the current Notice by contacting us.

COMPLAINTS
If you believe your privacy rights have been violated, you can file a complaint with Odyssey Pediatric Therapy Specialists Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. All complaints must be in writing. We will not retaliate against you for filing a complaint.
Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

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Acknowledgment of Receipt of Privacy Practices

I have been presented with a copy of Odyssey Pediatric Therapy Specialists Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____ _____

Parent / Legal Guardian Signature Date