Triumph Pediatric Center
4900 Massachusetts Ave, NW
Suite 340
Washington, DC 20016
Ph: 240.339.4976
Fax: 202.396.2437

Triumph Ortho Clinic
1331 H St, NW
Suite 200
Washington, DC 20005
Ph: 240.339.4976
Fax: 202.396.2437

Patient Intake Form

Name: _____ Initials and Date of call: _____

Appt date: _____ Time: _____ Therapist:_____

Who referred you to us?: _____

Was this the first time you heard of us? Y◯ N◯ If no, where?

Discipline requested: Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐

Patient Information:

Child: _____ DOB_____SSN_____

Parent Home Phone: _____ Parent Work Phone: _____

Parent Cell Phone: _____

Address: _____

Email address: _____Best time and way to reach you_____

Sex: M F

Child School: _____Address: _____

Emergency Contact:

Name: _____Relationship: _____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Referring Physician:

Name: _____Address: _____

Phone: _____ Fax: _____ Email: _____

Primary Care Physician:

Name: _____Address: _____

Phone: _____ Fax: _____ Email: _____

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Insurance Verification Form

Patient's Primary Insurance:

Primary Insurance: _____ Phone: _____

Patient's name: _____

Policy Holder Information:

Name: _____ Relationship: _____ DOB: _____

Employer: _____ SSN: _____

Policy ID Number: _____ Group Number: _____

Policy Information:

Covered Amount: _____ / _____% Co-pay: $_____ Deduct: $_____ Deduct met? _____

Referral req? _____ Pre-auth/Pre-cert req? _____ Effective date of policy: _____

Pre-auth/pre-cert phone: _____ Pre-auth/pre-cert fax: _____

Max # visits: _____ # of visits used: _____ Has pt had home health? Y◯ N◯
Dates: _____

Any policy exclusions/restrictions? _____

Insurance Contact: _____ Contacted by: _____ Date: _____

Mail claims to: _____

Notes: _____

I HAVE READ THE INSURANCE VERIFICATION AND I UNDERSTAND THESE BENEFITS ARE NOT GUARANTEED. THE ABOVE IS AN ESTIMATE FROM MY INSURANCE COMPANY. MY CO-PAYMENTS AND % OF RESPONSIBILITY IS DUE AT THE TIME I AM TREATED. IF I OWE MORE THAN THE INSURANCE COMPANY ORIGINALLY QUOTED, I WILL BE RESPONSIBLE FOR THAT AMOUNT. IF I OVER-PAY MY BILL, I WILL BE REIMBURSED THE AMOUNT I OVERPAID ONCE I AM DISCHARGED. I HAVE RECEIVED A COPY OF THIS VERIFICATION FORM.

Patient Signature: _____ Date: _____

Practice Representative: _____ Date: _____

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Patient Condition Form

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 Triumph Pediatric Clinic when my child's therapy is finished. In the event that another person will pick up my child, I will notify TPC.

Parent's Signature _____ Date _____

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Health History Form

Has your child received any of the following treatment(s) for your condition/injury?:

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other:

If yes to above, please describe: _____

Name and address of other doctors who have treated your child for this condition:

_____

_____

Has your child had any diagnostic testing:
☐ X-ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other _____
If you have had testing, please provide dates: _____
Has your child been diagnosed with any of the following conditions?

	Yes	No		Yes	No
Autism			Cerebral Palsy		
Cancer			Hearing or Visual Impairment		
Diabetes			Thyroid Problem		
Arthritis			Pseudobulbar affect		
High Blood Pressure			Vertigo		
Circulatory Problems			History of Falls		
Depression			High Cholesterol		
Seizures			Contagious Disease		
Heart Problems			Stroke		

Please list any other injuries or diagnoses not listed above: _____

Please list all past injuries and/or surgeries with dates: _____

_____

Are there any over-the-counter medication, vitamins or supplements? Y ○ N ○
If yes, please list: _____

Is your child currently taking prescribed medication? Y ○ N ○
If yes, please list:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Triumph Pediatric Center to obtain Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

TREATMENT COMMITMENT

Triumph Pediatric Center cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at Triumph Pediatric Center.

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment.

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

In an instance of cancellation, without 48 hours-notice, we reserve the right to charge you a $90.00 fee. In an instance of a no-show you will be charged the full amount of a visit. After the second no-show or third cancelled appointment all future appointments will be removed from the schedule and you will be added to our "same day appointment only" list.

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In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

By signing, Patient agrees & understands all items outlined above

_____ _____

Signature of Patient Date

_____ _____

Practice Representative Date

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Financial Policy

We are committed to providing you with the best in Therapy care. In order to do this without compromising our patients, this policy has been implemented for each patient. If you have medical insurance, we are happy to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

▪ Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard, Discover, and American Express. We will be accommodating to you in the process of seeking reimbursement from your Insurance carrier. In special instances, we may accept assignment of insurance benefits.

▪ Please be further advised that Returned checks and balances older than 30 days from your Treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month.

Please be aware of the following:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.
4. We will not COMPRISE patient care based on an insurance companies “FEE SCHEDULE”.
5. Verification of your insurance benefits is not a guarantee that payment will be made.

While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, **PLEASE don’t hesitate to ask us. WE ARE HERE TO HELP YOU!**

_____ _____

Signature of Parent Date

_____ _____

Practice Representative Date

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ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY AND AUTHORIZATION FOR TREATMENT

PATIENT: _____

1. THE UNDERSIGNED, hereby authorize Triumph Pediatric Center and its affiliates to render to Patient physical therapy, occupational therapy, speech therapy or other related services (collectively, "Therapy Services") that Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Therapy Services.

2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.

3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, patients Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.

5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.

6. THE UNDERSIGNED, authorizes Triumph Pediatric Center to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.

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7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider's invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.

8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.

9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.

10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest to Provider.

11. THE UNDERSIGNED understands that they have a choice or rehabilitation service providers.

_____ _____

Signature/Legal Representative Date

_____ _____

Practice Representative Date

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TRIUMPH THERAPEUTICS

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patientprivacyrights

Health Privacy Rights

Health Privacy "Rights" Under HIPAA

- Receive **notice** of how providers **use and share** your information with over 4 million "covered entities", **without asking you** ("Privacy Notice" or "Notice of Privacy Policies").
- The right to a copy of your health records. The provider may charge a "reasonable fee" for such copies.
- You can **request changes** to your health records. The provider does NOT have to make the changes requested. Your changes must be added to your records and the provider has to state reasons s/he disagrees with changes.
- You can **request an accounting of disclosures** of your health information. Most disclosures do not require consent and have no audit trails. Audit trails are required only for disclosures for "non-routine" uses.
- Health establishments and "covered entities" are required to **secure information** to the best of their ability, and a **privacy official** must be designated by each "covered entity."
- The ADA prohibits an employer from asking about health information or requiring a physical prior to an offer if they have more than 15 employees. After the offer is made, the employer may require a medical exam if it is required by all employees with similar positions. Employers may also ask employees to authorize disclosure of their medical records. **But, if the employer is self-insured they can access their employees' medical information without consent.**

Job discrimination is the most common complaint sent in to Patient Privacy Rights.

These rights are based on thousands of years of medical ethics, our own Constitution and state laws. None of these rights are provided by HIPAA.

Health Privacy Rights You Should Have

- Right to **control** who can see, use, share and sell your health information.
- Right to **feel safe talking truthfully** to your doctors.
- Right to privacy and control of health information unless otherwise stated or required by law.
- Right to be **notified of any breach** or possible breach of information.
- Right to **audit trails** of every disclosure of health information. Health IT makes it easier than ever to know exactly who has your information.
- Right to EHR and PHR systems that have the highest standards for **security (keep hackers out).**
- Right to participate in **research** and have researchers access your records ONLY if you give informed consent
- Right to **segment sensitive information** such as mental health, addiction or STDs, in your health record.
- Right to obtain **prescriptions** with privacy; no one should be able to use or sell your prescriptions without your consent.
- Right to obtain **employment, insurance, credit, admission to schools**, etc. without being compelled to share health information unless required by statute.

Patient Privacy Rights is working to ensure **these rights** are guaranteed by Congress.