Missed Visit Policy

At Southern Physical Therapy Clinic our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure that you understand that it is extremely important that you attend all of appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. **Please note:** Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. **If you're running late**, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled and, we reserve the right to charge our missed visit fee for the lost session. Chronically late patients will be asked to change their appointment times.
5. While we understand that illness can strike at any time, we still expect that you will work to provide at least a **24 hour** notice if you cannot attend a scheduled appointment.
6. Providing care to all patients is extremely important to us and late notice of changes or cancellations will keep someone else from getting the care they need and deserve. **If you need to cancel or change a scheduled appointment, for any reason, we require a 24 hour notice during business hours, so we have enough time to help another patient who needs to get in for the care they need and deserve.**
7. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
8. **We reserve the right to charge a missed visit fee of $50 if you do not provide at least a 24 hour notice of your appointment change or cancellation, and we will comply with payer policy in carrying it out.**
9. **To avoid our missed visit fee, we need you to call our office during business hours - at least 24 hours in advance for any illness, appointment changes or cancellations.**
10. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule, and will be placed on the day-to-day list to avoid future missed visit charges. We will also notify your physician.
11. If you're worker's comp, we are required to notify your claims adjuster if you cancel or no-show for an appointment.

We look forward to working with you to meet your physical therapy goals. **To avoid any issues with our policy, we only need the required notice, so we have enough time to help all patients to get in for the care they need and deserve.**

Adam Robin, Owner

This policy has been verbally reviewed with me and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date

Dear Valued Family,

We want to thank you for the opportunity to support you and your child during our time together. We look forward to a mutually healthy and happy relationship. Our experience in this field has taught us that your child may have a difficult time waiting patiently for their appointment to start. We all know how kids can be, and we love them for it. We are here to support you with this in the following ways.

1. We are asking all parties to limit to more than 1 caregiver per patient in the waiting room in order to increase available space.
2. We have established a designated **children area** in the waiting room included with toys and games to occupy them while they wait. We will continue to upgrade this area as we can.
3. We have provided strategic chair placement around the designated children area to allow you to **easily monitor and contain your little one** while they are waiting.
4. We promise to do everything in our power to start every single appointment on time so that you do not have to wait any longer than you anticipated.
5. Our entire staff has been trained and instructed to provide you with as much accommodation as is needed to ensure that you and your child have a successful experience with us.

With these accommodations, **we are also asking for your support** during your time with us. Our clinic is shared by our adult demographic, and this includes our older adults who are sometimes battling multiple ailments of their own. We are asking support from you in the following ways.

1. **Please keep your in the designated child area as they wait for their appointment.**
2. **Please do not allow your child to run, climb, jump, or roughhouse in the waiting room.**
3. **Please keep your child's yelling and screaming to a minimum.**
4. **Please do not let your child run free in the gym. There are plenty of large machines that can hurt your child if they are not tended to in the gym area.**
5. **Please ask us for any additional support you may need with this. We are happy to accommodate in any way that we can.**

Lastly, we completely understand that there are special cases in which this can be extremely difficult. We want you to know that we are here for you first and foremost. By signing below, you are acknowledging that you are promising to simply **do the very best that you can** at maintaining these guidelines including being the first to ask if / when you need any additional support.

Patient's Name: ______________________

Parent / Guardian: ______________________ Date: ______________

"We see people for who they are so they can see themselves for who they can become"

"We help you believe in yourself, so that you can see what is possible"

Pediatric Case History

General Information			
Child's Name:	DOB:	Age:	Gender: ☐ Male ☐ Female
Person Completing Form:	Relation to Child:		
Date:	Primary Guardian's Names & Relations:		
Guardians' Occupations:	Home Address:		
Phone Number:	Email Address:		
Preferred Contact Method: __Phone __Email	Referred By:		
Child's PCP:	Is the child toilet trained? ___yes ___no		
Briefly explain why this evaluation is being requested: ______ ______ ______			

Family History	
Please list all individuals living in the child's home:	
Name & Age:	**Occupation and/or relation to child**
Languages spoken in the home:	Child's Primary Language:
List any family history of speech/learning/motor disabilities if applicable: ______ ______	

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Birth and Medical History

At how many weeks was the child born? ____

Did the child require a NICU stay? __no __yes | If yes, how long was the NICU stay? ________

Please explain any significant pregnancy and/or birth complications if applicable:
____
____
____

Date of last hearing screening: ____________________
- ☐ Pass
- ☐ Fail

Date of last vision screening: ______________________
- ☐ Pass
- ☐ Fail

Does the child have a significant history of any of the following? (check all that apply)

- ☐ Tonsillitis
- ☐ Difficulty sleeping
- ☐ Snoring
- ☐ Breathing difficulties
- ☐ Frequent colds
- ☐ Head injury
- ☐ Broken bones
- ☐ Toe walking
- ☐ Persistent bed wetting (after toilet training)
- ☐ Seasonal allergies
- ☐ Nasal congestion
- ☐ Ear infections
- ☐ Hearing loss
- ☐ Vision Impairment
- ☐ Other: ________________________

Please list any active diagnoses the child has (i.e. Autism, ADHD, Cerebral Palsy, etc.) if any
____
____
____

Please briefly explain any surgeries/procedures the child has had (i.e. ear/PE tubes, tonsillectomy, orthopedic interventions, etc.) if any
____
____
____

Please list any adaptive equipment (wheelchair, AAC device, braces, etc.) the child uses if any
____
____

If necessary, Please explain any additional medical information that may be pertinent such as medications, allergies, pending diagnoses, etc.
____
____
____
____
____

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Developmental and Therapy History

Has the child been evaluated by any of the following Disciplines? (check all that apply)

______ Speech Therapy ______Physical Therapy _____Occupational Therapy

If yes, did they receive services by any of these disciplines? Please briefly explain the experience.

____

____

____

Please indicate the approximate age at which your child did the following

Babbled:	Rolled over:
Spoke First words:	Sat up:
Put two words together:	Crawled:
Spoke 3-4 word combinations:	Walked:

How does your child communicate currently? (check all that apply)

- ☐ Whinning/crying
- ☐ Pointing /gestures
- ☐ Looking at desired object
- ☐ Guiding adult's hand
- ☐ Reaching towards/ pushing away objects
- ☐ vocalizing/babbling
- ☐ Using single words
- ☐ Using 2-3 word phrases

My child currently communicates to: (check all that apply)

- ☐ Request
- ☐ Protest
- ☐ Comment
- ☐ Label objects
- ☐ Comment
- ☐ Seek affection
- ☐ Other:______________________________
- ☐ None of the above

Is your child aware of when they are not understood?

- ☐ No
- ☐ Yes

If yes, please explain how they react (i.e. become upset, try again, etc.)

____

____

Please indicate if your child can independently do any of the following:
(check all that apply if applicable)

- ☐ Hold a bottle
- ☐ Hold a spoon
- ☐ Drink from a cup
- ☐ Dress themselves
- ☐ Button Shirt
- ☐ Tie shoes

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Feeding History

Please indicate if your child has a history of any of the following:

- ☐ Thumb sucking
- ☐ Pacifier use
- ☐ Nursing difficulties
- ☐ Reflux/colic
- ☐ Tongue thrust
- ☐ Picky eater
- ☐ Food texture sensitivity
- ☐ Mouth breathing
- ☐ Excessive drooling
- ☐ Tongue tie
- ☐ Lip tie
- ☐ Food allergies
- ☐ underweight/ overweight (circle if needed)
- ☐ Coughing while eating
- ☐ Sensitive gag reflex

My child was:

- ☐ Bottle fed
- ☐ Breast fed

How long was your child on milk/formula?

____

Has your child ever required alternative forms of nutrition/feeding? (i.e. NG or PEG tube)

- ☐ Yes
- ☐ no

Please explain if necessary:

____

If applicable, please indicate any dietary restrictions due to allergies or religious practices:

____

Daycare/School Information

Does your child attend daycare or school?

- ☐ No (skip the rest of this section)
- ☐ Yes, homeschooled
- ☐ Yes, School/daycare name:________________________________

What grade are they in?__________________________________

What services does your child receive at school if any?

- ☐ Special education
- ☐ Behavior intervention
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Other:______________
- ☐ None

Personal Information

What are your goals for the child?:

____

____

Please list any interest the child may have:

____

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Please initial and date where indicated below:

Consent to Treatment

I hereby authorize the professional staff at Southern Physical Therapy Clinic to examine and treat me with physical therapy/occupational therapy/speech therapy for the injury and/or condition that I have been referred here for or referred myself to.

Patient/Caregiver Initial ______________________ Date ______________

HIPAA Regulations

I understand that Southern Physical Therapy Clinic complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for the purpose of securing payment. This authorization remains in effect until 90 days from the date of the last bill collected.

Patient/Caregiver Initial ______________________ Date ______________

Assignment and Instruction for Direct Payment to Health Provider

Insurance Company/Companies: ______________________________________

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to Southern Physical Therapy Clinic for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

Patient/Caregiver Initial ______________________ Date ______________

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Please initial and date where indicated below:

Release to Send Text and/or Email Appointment Reminders

By initialing below, I confirm and authorize Southern Physical Therapy Clinic to provide text message and/or email reminders to the provided cell phone number and/or email address. I understand that there will be personal appointment information that is protected under HIPAA law and accept responsibility for these reminders.

Patient/Caregiver Initial ____________________ Date ____________________

Confirm Receiving Copy of Non-Discrimination Policy

By initialing below, I confirm that I have received a written copy of Southern Physical Therapy Clinic's Non-Discrimination Policy. I have read and completely understood the policy and have been given the opportunity to clarify any misunderstanding.

Patient/Caregiver Initial ____________________ Date ____________________

Confirm Understanding of Formal Discharge Assessment Requirement

It is a medical necessity per your insurance provider that you complete a formal in person discharge assessment during your last scheduled appointment. An unplanned "self discharge" without completing a form discharge assessment is not covered without provided documented extreme circumstances. By initialing below, you are acknowledging understanding of this policy and are pledging your assurance that you will make every available effort to complete your agreed upon prescribed plan of care as well as completing a formal discharge assessment upon your last scheduled appointment.

Patient/Caregiver Initial ____________________ Date ____________________

Authorization For Use or Disclosure of Patient Photographic and/or Video Images

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing proposed by Southern Physical Therapy Clinic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Patient/Caregiver Initial ____________________ Date ____________________

1620 Hwy 11 N Suite C
Picayune, MS 39466
P: 769-242-2626
F: 769-242-2685

1601 W Central Ave
Wiggins, MS 39577
P: 601-716-3196
F: 601-974-9919

1337 Gause Blvd Suite #107/108
Slidell, LA 70458
P: 985-201-7032
F: 985-307-4050

"We see people for who they are so they can see themselves for who they can become"

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Discrimination is Against the Law

Southern Physical Therapy Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Southern Physical Therapy Clinic does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Southern Physical Therapy Clinic provides free aids & services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Southern Physical Therapy Clinic provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

if you need the services contact Southern Physical Therapy Clinic, compliance officer

if you believe the Southern Physical Therapy Clinic has failed to provide the services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can finally grievance with:

Southern Physical Therapy Clinic's Compliance Officer

1620 Hwy 11 N Suite C
Picayune, MS 39466
P: 769-242-2626
F: 769-242-2685

1601 W Central Ave
Wiggins, MS 39577
P: 601-716-3196
F: 601-974-9919

1337 Gause Blvd Suite #107/108
Slidell, LA 70458
P: 985-201-7032
F: 985-307-4050

Email: info@southernptclinic.com

You can file a grievance in person or by mail fax or email. If you need help filing a grievance, Southern Physical Therapy Clinic's compliance officer is available to help you.

You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/loby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Access Notice:

Southern Physical Therapy Clinic, and all of its programs and activities are accessible to and usable by disabled persons, including persons with impaired hearing and vision.

Access features include:

- Convenient off street parking designated specifically for disabled persons
- Curb cuts and ramps between parking areas and buildings
- Fully accessible offices, meeting rooms, bathrooms, public waiting area, patient treatment areas, including examining rooms
- A full range of assistive and communication aids provided to persons with impaired hearing vision, speech, or manual skills without additional charge for aids

If you require any of the aids listed above, please let the receptionist or your therapist know.