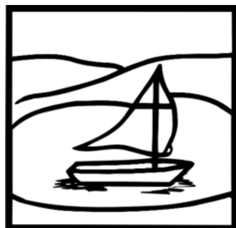

CAPERNAUM PEDIATRIC THERAPY, INC.

CORPORATE OFFICE: 7250 France Avenue, Suite 305, Edina, MN 55435-4313
PHONE (952) 285-2840 · FAX (952) 285-2830 · www.capernaumpeds.com

Outpatient Services at
ACADEMY OF WHOLE LEARNING

Dear Capernaum Parents/Guardians,

WELCOME to Capernaum Pediatric Therapy, Inc. serving children at the Academy of Whole Learning! We are excited to begin services for your child, and we will provide you with an experienced, reliable, and supportive therapist. We believe that the welfare of the child and his or her family should be the most important criteria by which any decision is made. You are an essential part of this team, as you know your child best. May we have a pleasant and productive working relationship with you, one that best serves your child's development.

SECTION I: Below is a list of the forms that need to **be completed and returned** before your child can begin treatment.

1) Service Agreement
2) Release of Information
3) Demographic and Insurance Information
4) Patient History

SECTION II: Below is a list of the forms for you to **keep for your information and reference**.

1) Client's and Family's Bill of Rights and Responsibilities
2) Attendance Policy
3) Annual Patient Privacy and Confidentiality Policy
4) How to Check Your Insurance Benefit Coverage
5) Copy of Service Agreement

Please complete the forms listed in **Section I** and return them to our office staff via U.S. mail, by fax (952-285-2830), or by email (Edina@capernaumpeds.com).

If you have any questions regarding these forms, you may contact our office at 952-285-2840. We look forward to building a relationship with you and your child.

Sincerely,

Bonna Olson, PT, Administrator

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2017 SERVICE AGREEMENT – Academy of Whole Learning

___ OT ___ PT ___ ST

Patient: ____ DOB: ________________

1. I agree to permit Capernaum Pediatric Therapy, Inc. to provide services to me and/or my minor dependents.
2. Anticipated frequency and treatment plan will be determined after the therapist's evaluation and described in the initial evaluation and assessment. Continual updates in the treatment plan will be made every 90 days and documented on the *Recertification*.
3. The rate for services is as follows: The initial evaluation will be billed at a flat rate of $360.00. A re-evaluation for occupational and/or physical therapy will be billed at a flat rate of $180.00. Treatment will be billed at $40.00 per 15 minutes of service or modality for occupational and physical therapy services. Speech and feeding therapy services will be billed at a flat rate of $160.00 per session. Your third party payor will be billed directly. You are responsible for any deductible, co-payments, co-insurance, out-of-network charges, or any other expenses not covered by insurance.
4. It is the parents'/guardians' responsibility to immediately inform Capernaum of any and all changes in insurance information, including group policy number, identification numbers, phone numbers, addresses, effective date, etc. FAILURE TO NOTIFY CAPERNAUM IN ADVANCE OF AN INSURANCE CHANGE WILL RESULT IN PARENTS/GUARDIANS BEING RESPONSIBLE FOR PAYMENT OF THERAPY SERVICES RENDERED BEFORE NOTIFICATION AND/OR PRIOR AUTHORIZATIONS CAN BE OBTAINED. IF YOUR ACCOUNT IS PAST DUE, CAPERNAUM RESERVES THE RIGHT TO SEND YOUR ACCOUNT TO COLLECTIONS AND/OR TERMINATE TREATMENT.
5. ASSIGNMENT OF BENEFITS: For therapy services rendered to me, or on behalf of any of my family members insured under this policy, I hereby authorize payment directly to Capernaum Pediatric Therapy, Inc. of all insurance benefits otherwise payable to me. Payment is not to exceed Capernaum Pediatric Therapy, Inc.'s regular charges for their services rendered for me or my family's benefit covered under this policy. I understand that I am financially responsible to Capernaum Pediatric Therapy, Inc. for charges not covered by my medical insurance policy or this authorization (i.e., co-pays, deductibles, etc.).
6. NO SHOW POLICY: It is important that your child receive his/her therapy services as scheduled. If there is no attempt to contact the therapist before a missed visit, it will be considered a "No Show." There will be a $30.00 charge **for no shows or late cancellations (less than 24 hours) except in the case of emergencies, illness, or dangerous weather**. After two no show visits, a reminder letter will be sent. After the third no show, therapy will be discontinued. Re-admission at a time when attendance would be more successful may occur on a first come, first served basis.
7. CANCELLATION POLICY: The frequency of your child's therapy has been agreed to by his/her therapist, physician, and you. This frequency has been determined to be the most beneficial for your child to maximize the therapeutic effect of treatment and to adapt the program to his/her changing skill levels. The more consistent the treatment and home program follow-through, the greater the success in goal achievement. If there are frequent cancellations, your therapist may need to decrease your child's treatment frequency so as to allow your child to be successful at making their treatment schedule and to allow another child an opportunity to receive treatment.
8. We will call 911 if there is an emergency unless a certified copy of a *Do Not Resuscitate (DNR)* order has been given to Capernaum.
9. Any questions or problems with services provided through Capernaum Pediatric Therapy, Inc. should be directed to Alison Bicek, OTR, Community Site Supervisor (952-285-2840) or Bonna Olson, PT, Administrator (612-922-2009). We as providers will in no way retaliate because of a complaint.
10. I have received and read the *Annual Patient Privacy and Confidentiality Policy.*

By signing below, I acknowledge that I have read and understand all of the above information.

______________________________________ ______________________
Parent/Guardian Signature **Date**

______________________________________ ______________________
Capernaum Representative Date

(Please review the above information, sign, date, and return.) Rev. 12/16/2016 (CS)

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2017 RELEASE OF INFORMATION

1. Personal Information

Patient's Name: ____ DOB: ________________

Person completing this form: ____

2. Purpose of Release

- ❑ I authorize the release of information for **ALL** of the following purposes: Continuation of care, insurance claims, litigation, personal, education, and others as necessary.

  To authorize the release of information for only specific purposes, please list: ____________________

  ____

3. Release Method(s) Permitted

- ❑ I authorize the release of information using **ALL** of the following delivery methods (paper, fax, verbal, email) unless otherwise specified:

4. Information To Be Released or Obtained

- ❑ I authorize the release of **ALL** pertinent medical information to/from Capernaum Pediatric Therapy, Inc. for the providers listed on page 2 of this document unless otherwise noted.

  To authorize the release of information for only specific purposes, please list: ____________________

  ____

5. Photo Consent and Release

CPT, Inc. occasionally videotapes/photographs for lectures, training, webpage, and/or marketing. I give CPT, Inc. permission to photograph/videotape my child for the following purposes:

Professional Lecture/Training: □ Yes □ No Webpage/Blog: □ Yes □ No
Marketing Materials: □ Yes □ No Facebook: □ Yes □ No

I expect no compensation or other remuneration. This consent, as to any use of said photographs, slides, television, videotape, or motion pictures, shall act to expressly release from liability the photographer, the therapist, and Capernaum.

6. Expiration: This authorization for release of information expires **February 1, 2018** unless otherwise indicated here:

This release is for (patient's name): ___________________________________ DOB: ________________

The information indicated on page 1 of this document may be released to the following agencies:

Primary Physician: ***(Required)*** *Please list doctor's name and/or name of clinic.*	Address:	
	Phone:	
	Fax:	
Primary Insurance Information: (***Required***) *Please list the name of insurance company*.	Address:	
	Phone:	
	Fax:	
Secondary Insurance Information: *(Required, if applicable) Please list the name of insurance company.*	Address:	
	Phone:	
	Fax:	
School: *Please list the name of school or school district along with any teachers or therapists.*	Address:	
	Phone:	
	Fax:	
Other Provider: *Please list other doctors, clinics, specialists, schools, therapists, social workers, guardians, emergency contacts, etc.*	Address:	
	Phone:	
	Fax:	
Other Provider:	Address:	
	Phone:	
	Fax:	
Other Provider:	Address:	
	Phone:	
	Fax:	

7. I understand that:

- I have the right to cancel this authorization at any time by written request. This will not apply to records already released.
- Once information has been released in compliance with this authorization, Capernaum Pediatric Therapy, Inc. is not responsible for re-disclosure of the information to a third party.
- To be valid, this form must be filled out completely and signed. An unaltered copy is considered as valid as the original.
- Capernaum Pediatric Therapy, Inc. will not make treatment a condition of me signing this form.
- Verbal and written information may be given to the caregiver bringing to, picking up from, and/or present for the patient's treatment.
- I authorize **Capernaum Pediatric Therapy, Inc.** to both release/obtain this patient's medical information to/from providers listed above.

Signature: ____ **Date:** ______________________

Relationship to patient: ____

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2017 DEMOGRAPHIC AND INSURANCE INFORMATION

NOTE: WE WILL DO OUR BEST TO DETERMINE YOUR INSURANCE BENEFITS; HOWEVER, IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS, I.E., DEDUCTIBLES, CO-PAYS, VISIT LIMITATIONS, ETC., AND TO BE RESPONSIBLE FOR THEM. WE ARE PROVIDERS FOR MOST INSURANCES BUT NOT ALL. YOU WILL BE RESPONSIBLE TO REIMBURSE CAPERNAUM THE PATIENT RESPONSIBILITY PORTION OF YOUR INSURANCE PLAN OR IF WE ARE OUT OF NETWORK.

PATIENT INFORMATION

Patient Name: ______________________________
Last First MI

Sex: M / F Date of Birth: ______________________________

Address: ____________________ City: ______________ State: _____ Zip: _________

Primary Phone: ______________________________

Emergency Contact Name: ______________ Relationship: ______________ Phone: ______________

RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN)

Name: ______________________________ Sex: M / F
Last First MI

Relationship to Patient: ______________ Email Address: ______________

Address: ____________________ City: ______________ State: _____ Zip: _________

Home Phone: ______________ Cell Phone: ______________ Best Daytime Phone: ______________

Other Parent/
Guardian Name: ______________________________ Sex: M / F
Last First MI

Relationship to Patient: ______________ Email Address: ______________

Address: ____________________ City: ______________ State: _____ Zip: _________

Home Phone: ______________ Cell Phone: ______________ Best Daytime Phone: ______________

INSURANCE INFORMATION

Primary Insurance Company Name: ______________________________

Policy Numbers: ______________ ______________
ID# Group/Plan#

Policy Holder: ______________________________ Date of Birth: ______________
Last Name First Name MI

Relation to Patient: ______________ Employer: ______________

Secondary Insurance Company Name: ______________________________

Policy Numbers: ______________ ______________
ID# Group/Plan#

Policy Holder: ______________________________ Date of Birth: ______________
Last Name First Name MI

Relation to Patient: ______________ Employer: ______________

Please notify Capernaum in advance of any insurance changes. Failure to notify Capernaum in advance of an insurance change will result in the parents/guardians being responsible for payment of therapy services rendered before notification and/or prior authorization can be obtained.

THANK YOU!

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PATIENT HISTORY

This form is intended to provide your therapist with information about your child's medical and social history. Although answering these questions is optional, please keep in mind that the more information the therapist can review prior to the evaluation, the more prepared he/she will be, and the more complete the evaluation will be.

Child's Name: ______________________________ DOB: ____________________

Person Completing This Form: ____

Relationship to Child: ______________________________Today's Date: ______________

1. Allergies (please list): ____
2. What medications/supplements is your child currently taking? What are they for? ____________________
____
3. Was your child premature? ☐ Yes ☐ No
   a. If yes, please indicate at what gestational week he/she was born: ____________________
4. Was the birth ☐ natural ☐ Cesarean section? Weight: ____________
   Was your child adopted? ☐ Yes ☐ No Was your child ever in foster care? ☐ Yes ☐ No
5. Were there any unusual conditions that may have affected the pregnancy or birth? ☐ Yes ☐ No ____________
____
6. Has your child been hospitalized for any other reason since birth? ☐ Yes ☐ No ____________________
____
7. Has your child had any surgeries/procedures (ex. Botox injections)? ☐ Yes ☐ No ____________________
____
8. Have there been any medical tests done on your child (X-rays, CT scan, vision)? ☐ Yes ☐ No
   When and where? ____
   What were the conclusions? ____
   ____
   Most recent vision evaluation: Date: ____________ Results: ____________________
   Most recent hearing evaluation: Date: ____________ Results: ____________________
9. History of middle ear infections: ☐ Yes ☐ No Most recent: ____________ Tubes placed: ____________
   Other treatment: ____
10. Does your child have any of the following? If yes, please check those items:
   - ☐ Heart defect/murmur
   - ☐ Seizures
   - ☐ Vision/hearing problems
   - ☐ Snoring/sleep apnea
   - ☐ Lung problems/Bronchial Pulmonary Dysplagia, Pneumonia, Asthma
   - ☐ Stomach/intestinal problems, reflux, constipation
   - ☐ Cardio-vascular impairment
   - ☐ Immunosuppressed

11. Has your child ever been diagnosed with any of the following? If yes, please check those items:

☐ MRSA ☐ RSV ☐ TB ☐ CMV ☐ HIV/AIDS ☐ Hepatitis A/B/C

NOTE: Your child will not be denied service as a result of you answering this question. Your answer will help determine the correct place of service and if any precautions are needed.

12. What is your child's primary mode of mobility (i.e., walk, crawl, wheelchair, crutches)? ____________________

13. Please list names and ages of people living at home: ____________________

____

14. Who suggested that your child receive therapy services from Capernaum? ____________________

15. Does your child receive any other therapies (i.e., homeopathic, chiropractic, ABA, etc.)? ☐ Yes ☐ No
(If yes, please record below. Use the back of this page if necessary.)

School/Agency	Type of therapy	Dates followed

16. What is your child's primary means of communication (gestures, words, crying, signing, PECS)? ____________________

17. Is English the primary language spoken in the child's home? ☐ Yes ☐ No
If not, please indicate primary language: ____________________

18. Any previous or current difficulty with feeding or swallowing? ____________________

Any dietary restrictions/food sensitivities/aversions? ____________________

19. Do you have any social/emotional/behavioral concerns? ☐ Yes ☐ No

If yes, please explain: ____________________

Have you sought assistance? ____________________

20. Are there any religious or cultural concerns you want us to be aware of? ☐ Yes ☐ No ____________________

____

21. Is there a time during your day that is more difficult than others? ____________________

22. What are your primary concerns (please provide examples)? ____________________

____

23. What are your goals for your child's therapy? (Please list for each discipline): ____________________

____

____

____

____

____

____

____

____

Client's and Family's Bill of Rights and Responsibilities

If your child receives rehab services, he or she has certain rights outlined in Minnesota law. As a parent or guardian, you may seek to enforce these rights.

Written information. You and your child have the right to receive written information about his or her rights before receiving care. The information must explain what to do if the rights are violated.

Current plan. You and your child have the right to receive care based on a suitable and up-to-date plan for his or her needs. If you don't think the plan of care meets your child's needs, then you have the right to discuss it with your therapist.

Participate in creating a plan. You and your child have the right to take an active part in creating and changing the plan of care and evaluating care services. You can have input in deciding what services your child needs. You have the right to receive your plan of care in writing.

Know who, what, and how often. You and your child have the right be told in advance what services will be provided, who will furnish the services, and how often the services will be provided. Your child also has the right to be told about other choices for services that are available.

Changes to plan. You and your child have the right to be told in advance of any change to the plan of care, and to take an active part in any decisions about changes to the service plan.

Refuse treatment. You and your child have the right to refuse services or treatment.

Limits. You and your child have the right to know in advance any limits to the services available. This means that you must be told what services the agency will not provide.

Coverage and charges. You and your child have the right to know in advance whether services are covered and the charges that will be made. We will do our best to inform you of your payment responsibility; however, it is ultimately up to you to know your insurance coverage and your out-of-pocket expenses.

Other services. You and your child have the right to know that other services may be available and how to get information on those services.

Choice. You and your child have the right to choose among agencies and the right to change agencies within limits of the health coverage.

Privacy and disclosure of information. You and your child have the right to have personal, financial, and medical information kept private and be told when and how the agency may disclose private information.

Access to information. You and your child have the right to see his or her records. You and your child have the right to prompt and reasonable responses to questions and requests.

Trained staff. You and your child have the right to be served by people who are competent and properly trained.

Courtesy and respect. You and your child have the right to be treated with courtesy and respect.

Freedom from abuse. You and your child have the right to freedom from physical and verbal abuse, neglect, financial exploration and all forms of maltreatment covered under the *Vulnerable Adult Act* and the *Maltreatment of Minors Act.*

Advance Notice. You and your child have the right to reasonable notice of changes in services or charges.

Termination. You and your child have a right to know the provider's reason for termination of services. You and your child have the right to at least ten days' advance notice of the termination of a service by a provider, except in cases where:

i) The client engages in conduct that significantly alters the terms of the service plan with the home care provider;

ii) The client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or

iii) An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

Transfer. You and your child have the right to a coordinated transfer when there is a change in the agency that provides services.

Complaints. You and your child have the right to make complaints if care is not given or if there is lack of respect or courtesy to your child or your child's property.

Contact. You and your child have the right to know who to call at the agency when there is a problem. The agency must investigate and try to resolve the problem.

State Contact. You and your child have the right to know what state or county agency to call for information or assistance. The home care agency must give you the information you need to contact the state or county agency.

Enforcement. If you want to enforce your child's rights, you may contact the Office of Health Facility Complaints:

Minnesota Department of Health
Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
(651) 215-8702 voice
(800) 369-7994 toll-free
E-mail: ohfc@mdh-fpcl.health.state.mn.us

If your child receives rehab services through Capernaum, the following are your responsibilities:

- You will tell us immediately if you think something doesn't look right or if you have questions about what is happening.
- You will provide accurate and complete information about your child's health and needs.
- You will ask questions when you do not understand information about your child's care and what is expected of you.
- You will be committed to following your child's treatment plan that was agreed upon by you, your child's physician, and therapist.
- You will show respect and consideration to other children, educators, therapists, and property.
- You will meet the financial obligations you have agreed to.
- You will tell us if you feel your child is unsafe or in pain.

Adapted from a fact sheet provided by The Health Information and Advocacy Center,
a project of PACER Center, Inc.

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ATTENDANCE POLICY

► ***Please keep this form for your records.*** ◄

CANCELLATION POLICY

The frequency of your child's therapy has been agreed to by his/her therapist, physician, and you. This frequency has been determined to be the most beneficial for your child to maximize the therapeutic effect of treatment and to adapt the program to his/her changing skill levels. The more consistent the treatment and home program follow-through, the greater the success in goal achievement.

NO SHOW POLICY

It is important that your child receive his/her therapy services as scheduled. If there is no attempt to contact the therapist before a missed visit, it will be considered a "No Show." There will be a $30.00 charge for no shows or late cancellations (less than 24 hours) except in the case of emergencies, illness, or dangerous weather. After two no show visits, a reminder letter will be sent. After the third no show, therapy will be discontinued. Re-admission at a time when attendance would be more successful may occur on a first-come, first-served basis.

HOME-BASED ONLY: If you need to cancel a visit, please make every effort to contact the therapist directly, not the administrative office. Try to let the therapist know 24 hours in advance. Be sure to keep your therapist's phone number/s in a handy location, or record their number/s below.

ATTENDANCE DUE TO CHILD'S ILLNESS

Capernaum's therapists are concerned about treating any child who is ill, as well as protecting other children and staff.

SYMPTOMS: Your child should not be seen for 24 hours after starting antibiotic and/or antivirus medication, or 24 hours after the following symptoms:

- fever of 100 degrees or more
- vomiting
- diarrhea
- excessive coughing
- excessive green nasal drainage
- sore throat

If a therapist is unable to provide service for more than two weeks due to illness, vacation, etc., every effort will be made to provide a substitute therapist.

Please keep the following information for your reference.

Therapist's Name: ________________________________ Contact #: ________________________________

Therapist's Name: ________________________________ Contact #: ________________________________

Interpreter's Name: ________________________________ Contact #: ________________________________

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ANNUAL PATIENT PRIVACY AND CONFIDENTIALITY POLICY

At Capernaum Pediatric Therapy, Inc., we value our clients and are very careful in the way we safeguard health information. "Protected Health Information" (PHI) is patient-identifiable information, whether oral, electronic, or paper, which is created or received by Capernaum Pediatric Therapy and relates to a client's healthcare or payment for the provision of service. We understand that the medical information about your child is personal, and we are committed to protecting the confidentiality of that information, wherever generated or used. This privacy and confidentiality policy will review how Capernaum Pediatric Therapy, Inc. may disclose your child's personal health information, where the information is stored, and your rights regarding medical information we maintain about your child.

How We May Use and Disclose Protected Health Information About Your Child

The following categories describe different ways that Capernaum Pediatric Therapy, Inc. may use and disclose protected health information. Not every use or disclosure is listed, however, all ways we are permitted to use and disclose information will fall within one of the following categories.

- For Treatment and Health Care Operations: We may use your child's medical information to provide, coordinate, or manage your therapy services, including coordination or management with a third party, and consultation between health care providers both within and outside of Capernaum Pediatric Therapy, Inc. We may also disclose information to business associates so that they may provide services (ex. billing clearinghouses, legal services) to Capernaum Pediatric Therapy, Inc. We may also disclose information to individuals involved in your care (family member, personal care attendant, nanny, etc.) unless notified in writing. *For example, your child's M.D. may call and ask about your child's progress.*
- For Payment: We may use and disclose medical information to your insurance carrier or third party payor in relation to obtaining payment for service(s). *For example, we may need to give information about your child's treatment, visit notes, etc. to your health insurance plan provider so they will pay for the services.*
- In Event of a Disaster or Serious Threat to Health or Safety: We may disclose your child's personal information to other health care providers and to an entity assisting in a disaster relief effort to coordinate care, so your family can be notified about your child's condition or location. We may also disclose information to prevent or lessen a serious threat to your child's health and safety. We can share information about your child to prevent disease, help with product recalls, report adverse reactions to medication, or suspect abuse, neglect, or domestic violence.
- As May be Required by Law: We may disclose your child's personal information in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; to report about criminal conduct, or in emergency situations to report a crime, the location of crimes or victims, or the identity, description, or location of the person who committed the crime. *For example, the court may subpoena your child's medical records.*
- Quality Assurance and Surveys: Your information may be shared within Capernaum Pediatric Therapy, Inc. in chart reviews to ensure compliance and the integrity of services provided to your child. We may also disclose your child's medical information if requested by representatives of the commissioner authorized to survey or investigate home care providers, or other state or federal agencies with authorization to review records, as well as authorized personnel from insurance companies authorized to do audits to ensure compliance and the integrity of the services provided. *For example, DHS may come to do a review of Capernaum, and they will review our medical records.*
- Research: We can use or share information for health research.

Storage of Personal Health Information

- Permanent paper charts for clients seen before 4/4/2016 by Capernaum Pediatric Therapy, Inc. will be housed at the Edina office (7250 France Avenue, Suite 305, Edina, MN 55435). These charts are not to be removed until after one calendar year following discharge from services. At that time, the chart may be transported to a secure location for storage.

- Working files may be kept by each therapist at their office. These files will be kept in a secure place and will not be available to others unless a *Release of Information* has been signed.
- All current client records are in our EMR (electronic medical records) system which is password protected and encrypted.

Your Rights Regarding Your Child's Medical Information

- Right to Inspect and Copy: You have the right to inspect and copy any medical information that may be used to make decisions in your child's care. This usually includes medical and billing records. For a full file copy, a request must be submitted in writing to the owner. Requests may be denied in very limited circumstances (release of psychological therapy notes) if deemed to be in the best interest of the child.
- Right to Request an Amendment: If you feel that medical information we have on file is inaccurate or incomplete, you may ask us to amend the information. Your request must be made in writing and submitted to the owner. In addition, you must provide a reason that supports your request. We may deny the request if the amendment request relates to information not created by Capernaum Pediatric Therapy, is not part of the medical information kept by us, or if the information currently on file is deemed accurate and complete. At any time, you may submit information to be included in your child's file.
- Right to Request Restrictions and Alternative Communication:
    1. You have the right to request a restriction or limitation on our use or disclosure of your child's protected health care information. Such requests must be in writing. If we agree to a restriction, we will comply with your request unless the information is needed to provide emergency treatment.
    2. You also have the right to request alternate communication methods when discussing your child's care or records. We will accommodate all reasonable requests. Information held electronically will be provided in electronic form, if requested.
    3. You have the right to restrict disclosure of PHI to your health insurance company for payment if the services and items provided during a visit have been paid in full by the patient or their guardian.
    4. You may also restrict information in regards to family members, disaster relief, in a directory, or for fundraising.

For further information regarding your rights, please contact the MN Department of Health at 651-201-5178, view the "Access to Health Records Notice of Rights" online at http://www.health.state.mn.us/divs/hpsc/dap/notice.pdf, or visit www.health.state.mn.us for more information about specific rights.

Our Responsibilities

We are required by law to maintain the privacy and security of your child's protected health information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your child's information. We will not use or share information other than as described here unless you tell us we can in writing. You may change your mind at any time as to who you want us to share information with; however, you must inform us of this change in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Capernaum Pediatric Therapy, Inc. or with the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

To file a complaint with Capernaum, contact:
Capernaum Pediatric Therapy, Inc.
Attn: Bonna Olson, Owner
7250 France Avenue, Suite 305
Edina, MN 55435-4313
Phone: 952-285-2840

To file a complaint with the Department of Health and Human Services, contact:
U.S. Dept. of Health and Human Services Office for Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
Phone: 1-877-696-6775
www.hhs.gov/ocr/hipaa

Changes to this Notice: Capernaum Pediatric Therapy, Inc. reserves the right to change the terms of this notice and make new notice provisions effective for all protected health information that Capernaum Pediatric Therapy, Inc. maintains.

NOTE: You may request an electronic copy of this policy, if you so desire.

CAPERNAUM PEDIATRIC THERAPY, INC.

CORPORATE OFFICE: 7250 France Avenue, Suite 305, Edina, MN 55435-4313
PHONE (952) 285-2840 · FAX (952) 285-2830 · www.capernaumpeds.com

HOW TO CHECK YOUR INSURANCE BENEFIT COVERAGE

As noted on the **Demographic and Insurance Information** form that you completed, *"We will do our best to determine your insurance benefits; however, it is your responsibility to know your insurance benefits, i.e., deductibles, co-pays, visit limitations, etc., and to be responsible for them. We are providers for most insurances but not all. You will be responsible to reimburse Capernaum the patient responsibility portion of your insurance plan if we are out of network."*

Prior to your child's appointment, we will contact your insurance company to determine as best we can if services are covered. However, it is important that you understand your plan's coverage as well. Follow the outlined steps below in order to check your coverage:

- Contact member services. Their phone number will be on the back of your insurance card. Be sure to have your ID and group number ready and follow the prompts.
- Speak the word "representative" if you get stuck in an automated system. Most times this will connect you with someone you can talk to directly.
- You will be asked what benefit you are checking – physical, occupational or speech therapy. (**Note that services will be considered habilitative unless it is the result of an illness or injury. Rehabilitative therapy helps a person regain a skill they have had in the past.)**
- Things you will want to ask:
  - Does my plan cover OT, PT, or ST for my child?
  - What is my co-pay for (PT/OT/ST) therapy at home?
  - If my child has multiple therapy appointments on the same day, will I be charged a co-pay for each session?
  - Is there a deductible? If so, how much of that deductible has been satisfied?
  - Is there a co-insurance? If so, what is my portion?
    (Co-insurance is the percent you are required to pay. For example, the insurance company may pay 80%; therefore, your portion is 20%.)
  - Is there a visit limit? If so, how many visits are allowed each year, and how many visits have been used? Is that combined with any other discipline (i.e., 60 visit combined limit for OT, PT, ST, nursing)?
  - Does my plan require a referral?
  - Are there any other limits such as age or illness/injury?
  - My child has been diagnosed with ______________ (i.e., development delay, autism, etc.). Is this a covered diagnosis under my plan?
  - Write down the name of the insurance representative and the date you spoke with them.

If there is something you need help understanding, you may contact your benefits coordinator through your employer, or you may contact Capernaum Pediatric Therapy, Inc. at 952-285-2840, and we will be happy to help you.

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►*Keep this copy for your records.*◄

2017 SERVICE AGREEMENT – Academy of Whole Learning

___ OT ___ PT ___ ST

Patient: ______________________________ DOB: ______________

1. I agree to permit Capernaum Pediatric Therapy, Inc. to provide services to me and/or my minor dependents.
2. Anticipated frequency and treatment plan will be determined after the therapist's evaluation and described in the initial evaluation and assessment. Continual updates in the treatment plan will be made every 90 days and documented on the *Recertification*.
3. The rate for services is as follows: The initial evaluation will be billed at a flat rate of $360.00. A re-evaluation for occupational and/or physical therapy will be billed at a flat rate of $180.00. Treatment will be billed at $40.00 per 15 minutes of service or modality for occupational and physical therapy services. Speech and feeding therapy services will be billed at a flat rate of $160.00 per session. Your third party payor will be billed directly. You are responsible for any deductible, co-payments, co-insurance, out-of-network charges, or any other expenses not covered by insurance.
4. It is the parents'/guardians' responsibility to immediately inform Capernaum of any and all changes in insurance information, including group policy number, identification numbers, phone numbers, addresses, effective date, etc. FAILURE TO NOTIFY CAPERNAUM IN ADVANCE OF AN INSURANCE CHANGE WILL RESULT IN PARENTS/GUARDIANS BEING RESPONSIBLE FOR PAYMENT OF THERAPY SERVICES RENDERED BEFORE NOTIFICATION AND/OR PRIOR AUTHORIZATIONS CAN BE OBTAINED. IF YOUR ACCOUNT IS PAST DUE, CAPERNAUM RESERVES THE RIGHT TO SEND YOUR ACCOUNT TO COLLECTIONS AND/OR TERMINATE TREATMENT.
5. ASSIGNMENT OF BENEFITS: For therapy services rendered to me, or on behalf of any of my family members insured under this policy, I hereby authorize payment directly to Capernaum Pediatric Therapy, Inc. of all insurance benefits otherwise payable to me. Payment is not to exceed Capernaum Pediatric Therapy, Inc.'s regular charges for their services rendered for me or my family's benefit covered under this policy. I understand that I am financially responsible to Capernaum Pediatric Therapy, Inc. for charges not covered by my medical insurance policy or this authorization (i.e., co-pays, deductibles, etc.).
6. NO SHOW POLICY: It is important that your child receive his/her therapy services as scheduled. If there is no attempt to contact the therapist before a missed visit, it will be considered a "No Show." There will be a $30.00 charge **for no shows or late cancellations (less than 24 hours) except in the case of emergencies, illness, or dangerous weather**. After two no show visits, a reminder letter will be sent. After the third no show, therapy will be discontinued. Re-admission at a time when attendance would be more successful may occur on a first come, first served basis.
7. CANCELLATION POLICY: The frequency of your child's therapy has been agreed to by his/her therapist, physician, and you. This frequency has been determined to be the most beneficial for your child to maximize the therapeutic effect of treatment and to adapt the program to his/her changing skill levels. The more consistent the treatment and home program follow-through, the greater the success in goal achievement. If there are frequent cancellations, your therapist may need to decrease your child's treatment frequency so as to allow your child to be successful at making their treatment schedule and to allow another child an opportunity to receive treatment.
8. We will call 911 if there is an emergency unless a certified copy of a *Do Not Resuscitate (DNR)* order has been given to Capernaum.
9. Any questions or problems with services provided through Capernaum Pediatric Therapy, Inc. should be directed to Alison Bicek, OTR, Community Site Supervisor (952-285-2840) or Bonna Olson, PT, Administrator (612-922-2009). We as providers will in no way retaliate because of a complaint.
10. I have received and read the *Annual Patient Privacy and Confidentiality Policy*.

By signing below, I acknowledge that I have read and understand all of the above information.

______________________________ ______________
Parent/Guardian Signature **Date**

______________________________ ______________
Capernaum Representative Date

(Please review the above information, sign, date, and return.) Rev. 12/16/2016 (CS)