PILLER CHILD DEVELOPMENT

Client Information

Child's Name_____ Date of Birth_____

Address _____

City _____ State _____ Zip _____

Email _____

Phone _____

Primary Care Physician _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

10631 S 51st St, Suite 8 Phoenix, AZ Phone 480-398-4280 Fax 480-398-4281

PILLER
CHILD
DEVELOPMENT

Insurance Information

Primary Insurance Company_____

Policy Holder _____ Employer _____

Relationship to Patient _____ Date of Birth _____

ID or Policy # _____ Group # _____
Marketplace plan __yes ___no

Secondary Insurance Company_____

Policy Holder _____ Employer _____

Relationship to Patient _____ Date of Birth _____

ID or Policy # _____ Group # _____

Medical Information Release
I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies, third party payers, or other health care agencies. A photocopy of this assignment is considered as valid as the original. I also authorize the release of medical records or copies of such and request that they be transferred to Piller Child Development, LLC.

Assignment of Benefits
I request that payment of authorized insurance benefits be made on my behalf to Piller Child Development, LLC.

Signature _____ Date _____

Consent for Care
I, the undersigned, to hereby agree and give my consent for Piller Child Development to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition.

Signature _____ Date _____

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

Payment/Cancellation/Participation Policy for Client Receiving Services through the Division of Developmental Disabilities

Missed Appointments /Cancellations/No Shows

Missed appointments represent a cost to us and other patients who could have been seen in the time set aside for you. Patients are asked to give 24-hours notice. If a patient has more than 2 cancellations within a 4-week period or 2 or more "no shows," the patient is subject to loose their scheduled time and will need to find another time on the schedule that is more conducive to meet their needs. However, if a patient has 2 or more "no shows" or more than 2 cancellations in a 4 week period they are subject to loosing their spot on the schedule and need to find a new time for services. In addition, the support coordinator will be notified to help ensure the client is receiving services and resolve any issues that may arise.

Insurance

We bill participating insurance companies. DDD is a payer of last resort. Therefore, we bill your primary and secondary (if applicable) insurance before billing DDD. You are required to notify Piller Child Development of any changes in insurance coverage as soon as the change occurs. Updated insurance cards, photo identification, and script for services are required for all clients.

Parent Participation

It is essential that family/caregiver training be an ongoing part of the therapy process. Parents/ caregivers are encouraged to participate in therapy sessions to ensure carryover with the treatment plan in environments outside of the clinic setting. Parents are provided with specific home program recommendations which are followed up on and adjusted at each session. Therapist are to provide home program recommendations that fit the needs of the family structure. Techniques used in therapy and home program recommendations can be provided in a variety of formats including demonstration, written, or verbal. All parent participation and home programs should be documented in the patient chart. Caregivers and parents of clients receiving services through DDD must remain in on the premise at all times during the child's therapy session. Parents are encouraged to be an active participant within the therapy session. This allows the therapist and caregiver to work closely together to ensure carry over in various environments.

continued on next page

Location of Services

I understand that all services with DDD performed through Piller Child Development must be performed at the Mesa location. No other Piller Child Development location is certified to perform services through the Department of Developmental Disabilities. All LTC insurance through DDD will not be accepted at any other Piller Child Development.

I understand and agree to the above policies.

_____ _____

Parent/Guardian Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Piller Child Development's Notice of Privacy Practices.

_____ _____

Parent or legal guardian signature Date

_____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)

I authorize and agree that Piller Child Development may disclose my protected health information to the following persons, each of who is directly involved in my care: (Please list pcp, and other doctors or therapists that you would like to receive copies of reports)

Name	Relationship to Child	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge and agree that Piller Child Development may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Piller Child Development.

Piller Child Development may contact me via the following manners:

Phone	☐ yes ☐ no	Leave Message	☐ yes ☐ no
Text Message	☐ yes ☐ no		
Email	☐ yes ☐ no		

_____ _____

Signature Date

_____

Printed Name

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.