COUNTRY KIDS
Pediatric Therapy Clinic

1142 Orlando Drive • De Pere, WI 54115
(920) 339-0700 • www.countrykidsinc.net

Dear Parent/Guardian:

Enclosed please find copies of Country Kids, Inc. intake forms for request of Physical and Occupational Therapy. Included in your packet you should find:

- **Privacy Notice** (information regarding the handling of personal health information)
- **Intake Form**
- **Parent Questionnaire**
- **Policy/Procedure for Admitting a Child into Services**
- **Billing Policies and Procedures**
- **Service Agreement**
- **Consent Form**
- **Consent to Video and/or Photograph**
- **Authorization to Provide Medical Treatment**

All Families:
Before your child receives services at Country Kids, Inc. all documents must be reviewed, completed as instructed, signed, and returned to our administrative staff. If you have received your packet via mail, please complete the intake and service agreement and return completed forms to our office with a copy of insurance cards (front and back). Please complete all forms completely and thoroughly to prevent delays in initiating programming. Administrative staff will call to go over coverage and schedule the evaluation once the paperwork is reviewed.

Hippotherapy/Therapeutic Riding:
If you are interested in Hippotherapy or Therapeutic Riding, please contact Exceptional Equestrians directly at (920) 347-3174 or via email at lkpediatrics@aol.com. Hippotherapy is no longer provided as part of OT/PT due to changes in third party reimbursement policies. Please see the website, www.exceptionalequestrians.org for more information and to download the forms to participate.

If you have any questions regarding Country Kids, Inc. policies or procedures, please call Lisa Kafka, OTR at (920) 339-0700.

Sincerely,

Lisa Kafka, OTR, C/NDT, HPCS
Administrator, Country Kids, Inc.

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INTAKE FORM

Date: _____

Patient Name:_____
DOB:_____
Parent/Guardian:_____ Email: _____
Address:_____ City/ST/Zip:_____
Home Phone:_____ Cell Phone: _____
Diagnosis:_____ Preferred Contact#: Home _____ Cell _____
Reason for Referral:_____
Date of Referral:_____ Referred by:_____

Primary Physician:_____
Clinic Name:_____ Address:_____
Clinic Phone:_____ City/ST/Zip:_____
Prescription Enclosed? Yes _____ Will be faxed _____

Primary Insurance Name:_____
Employer: _____
HMO, PPO, or Managed Care?: _____
Policy Holder:_____ DOB: _____
ID#: _____Group #: _____
Mailing Address:_____City/ST/Zip:_____
Insurance Plan Contact Person: _____ Phone: _____
Fax (to send in medical notes, if given): _____
Is service requested a covered service?: Yes No Unsure
Prior Authorization Obtained?: Yes No
Note: If prior authorization for services must be obtained prior to start date, we can help complete this process.

Secondary Insurance Name:_____
Policy Holder:_____ DOB: _____
ID#:_____ Group#:_____
Address:_____City/ST/Zip:_____
Phone: _____

Medical Assistance/Katie Beckett #:_____
Have you accessed Wisconsin Medicaid in the past to cover therapy services? YES NO
Is there an existing prior authorization for therapy in effect for your child? YES NO

Parent Questionnaire

Current Height: _____ **Current Weight:** _____

Medical History: (Please describe birth history and medical information that is relevant to your child's treatment.)
_____
_____
_____
_____

Allergies: _____
_____

Medication List: _____
_____
_____
_____

Recent Medical/Surgical Procedures: _____
_____
_____
_____
_____

Please list any recent medical concerns: _____
_____
_____

Nutrition: (How is your child fed? i.e. oral or g-tube/j-tube feedings / average caloric intake / main calorie source)
_____
_____

Please list any sensitivities you observe in your child: (such as sensitivity to touch/sounds/activities/etc.)
_____
_____
_____

Sleep Pattern: (Does your child sleep through the night? If so, average number of hours? If not, what are the issues you observe?) _____
_____
_____

Communication: (How does your child communicate? Please list current system if using technology.)
_____
_____

Therapy History: (Please describe therapy services your child has received or continues to receive including discipline (OT/PT/ST), frequency, location and indicate whether these services remain in effect.) _____
_____
_____
_____

Therapeutic Procedures: (Please describe any techniques you or your therapist are using or have utilized in the past, i.e. therapeutic listening, Botox, diet, baclofen, etc.) _____
_____
_____
_____

(TURN OVER TO PAGE 2)

Equipment: (Does your child use any special equipment at home or in school, such as a wheelchair, stander, braces, adapted bicycle, etc.) _____

Treatment Goals: (What are your goals for your child?) (What goals does your child have?) _____

Strengths/Abilities: (What do you feel are your child's strengths?) _____

Limitations: (What limitations do you feel are most prohibitive to achieving your goals?) _____

Precautions/Additional Information: (Please indicate any additional information you would like us to consider such as; sensory aversions, fears, likes/dislikes etc.) _____

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Procedure for Admitting a Child into Services

1. *Prescription*:

A physician prescription is required for all children, whether requesting OT or PT services. If a child has been discharged from services and is being re-admitted, a new prescription is necessary.
The prescription should read: "OT or PT evaluation and treatment." **Please also request that your physician include an ICD-9 diagnosis code on the prescription.**

2. *Prior Authorization*:

Insurance:

Prior to enrolling your child into services at Country Kids please check with your insurance company to be sure we are a provider.

In addition:

- If you have insurance coverage, it is necessary to pre-authorize OT and PT services **before** evaluation or treatment begins. Prior authorization will be obtained by our office staff once all insurance information has been provided to us. **Please submit a copy of the front and back of your insurance card.**

Insurance prior approval must be obtained even for those families who are also covered by Medical Assistance as MA requires that insurance be billed first.

Medical Assistance:

For all patients accessing Wisconsin Medicaid/Medical Assistance to cover all or part of therapy costs, a **prior authorization is required**. Wisconsin Medicaid requires that private insurance be billed prior to accessing Medical Assistance. Submitting a prior authorization does not guarantee approval for therapy services, therefore treatment typically does not begin until Medical Assistance approval is obtained (exceptions are sometimes made in case of acute needs, i.e. post surgical intervention). For patients with prior authorization approval, no expense is accrued for treatment with the exception of co-payments due if applicable (see medical assistance recipient handbook). Patients who are **denied** prior authorization for services through Medical Assistance, but **who choose** to receive services regardless will receive an invoice for services rendered, and will be responsible for payments due.

The prior authorization process involves a thorough evaluation followed by submission to MA of all necessary paperwork. All families covered by MA should submit the following items to Country Kids:

- Physician prescription
- All required forms in parent packet signed and dated
- Copy of MA card
- Copy of recent school IEP
- Copies of recent school OT, PT evaluations
- Medical history; including birth history, surgical reports

All paperwork must be turned in to the office before an evaluation will be scheduled.

3. Attendance:

Please contact the office at (920) 339-0700 if you cannot make your appointment. Be advised that if your child misses 3 sessions without notice services can be suspended or terminated via written correspondence.

4. Unpaid Balances:

Services will be suspended for families with an unpaid balance of $200 or more. This applies to insurance deductible, co-payments, private pay options and those families who choose to continue services despite MA denial.

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Billing Policies and Procedures

1. ***Service Rates***:
   Current rates for occupational and physical therapies are as follows:
   Evaluation……$200.00/hour (includes IFSP)
   Treatment…….$200.00/hour (equivalent to $50/unit of treatment) Effective 1/1/14

   Rates are subject to change. Clients and third party payers will be notified in writing of all rate changes.

2. ***Family Responsibility*:**
   Families with insurance coverage only, or who have been denied services through the MA prior authorization process are responsible for meeting the deductible. Country Kids, Inc. will bill insurance and any charges not covered due to deductible will be billed to you. If full amount cannot be paid at once, a payment plan can be established with the clinic.

   Families are also responsible for partial payment if insurance coverage is not at 100%, and a secondary insurance is not billable.

   Families are also responsible for any co-pay amounts due. These should be paid at time of visit, but a payment plan can be established.

   Families with Medical Assistance coverage will not accrue any expense, unless services have been denied by MA through the prior authorization process and family has chosen to continue with services. Coverage of evaluation is not a guarantee. If denied, private pay policies will apply. Families with MA will be informed of denials prior to determining continuation of care.

3. ***Billing Policy and Procedure*:**
   We are required to bill the primary insurance first. Therefore, it is important for families to contact the insurance company and establish prior authorization to ensure coverage (see admitting procedures). Typically, if services have been pre-authorized insurance will cover 70-80% of the bill. The secondary insurance if applicable may then be billed for the remainder.

   For families with Medical Assistance or Katie Beckett coverage, an approved prior authorization from Forward Health is necessary prior to billing MA. If services are approved, MA will be billed for therapy services after the primary and secondary insurance have denied the claim.

   If a prior authorization is denied by MA, families may choose to continue services, and therefore accept responsibility for payment of claims not covered by insurance.

4. ***Denied Insurance Claims*:**
   Denial of insurance claims can often be prevented by using the prior authorization process. On occasion payment of claims may be suspended due to case review etc. Families are typically informed of held claims via an explanation of benefits or a letter. Following review, most claims are re-authorized and payment will resume. Upon receipt of insurance notification that a claim is being held, families may choose to suspend treatment until reimbursement status is determined to avoid personal responsibility for payment of claim. It is often helpful for families to contact an insurance representative to assist in "speeding up" the process of case review.

5. ***Changes in Insurance Coverage*:**
   Families must notify Country Kids, Inc. immediately of any changes in reimbursement status. Please present a copy of your insurance and/or MA card at initial visit, and MA card monthly thereafter. Denied claims due to failure to inform clinic of change in reimbursement may result in suspended services.

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Service Agreement

Name of Child: _____
DOB: _____
Parent/Guardian: _____
Address: _____
Phone: _____

Please attach a copy of:

- Primary Insurance card (front and back) and indicate policy holder name and date of birth
- Secondary Insurance card (front and back)
- Medical Assistance/Katie Beckett card

Note: We will need to see the Medical Assistance card each month if you are accessing these funds. Also, parents/caregivers are **required** to notify Country Kids, Inc. immediately of **any** changes in insurance.

Fees For Service:
Evaluation (OT/PT)……$200.00 (includes IFSP)
Treatment (OT/PT)……$200.00 per Hour (equivalent to $50.00 per 15 minute unit) Eff. 1/1/14

Please review the following information carefully before signing and returning:

I understand that services are by appointment only. If it is necessary to cancel an appointment, I will contact the clinic at least 24 hours in advance unless circumstances are such that 24 hour notice is not possible (i.e. weather condition, illness).

I also understand that services provided to my child will be dependent upon reimbursement from: insurance, Medical Assistance, and/or private pay, per attached billing policies and procedures. In signing this form I acknowledge that I have read and understand billing policies and procedures. I will be responsible for showing my MA card to the therapist or billing personnel each month. It will be my responsibility to notify clinic of a change in reimbursement status, i.e. change in insurance company, policy holder, enrollment in an HMO, PPO or loss of coverage. Failure to notify Country Kids, Inc. of a change in coverage may result in a balance due to me.

I understand that Country Kids, Inc accepts MA as a form of reimbursement, however it is understood that if I have insurance as a primary source of payment, my insurance must be filed first. I also understand that prior authorization is required prior to all MA billing.

If prior authorization is approved, I understand that the clinic will bill MA for all eligible services, and that there will be no charge to me. If my child should lose eligibility, I will notify the clinic immediately as I understand that the prior authorization will then be void. I understand that services will be put on hold during periods of non-reimbursement such as ineligibility, prior authorization denial, termination of coverage, until such time that coverage is reinstated.

If the full and complete prior authorization is denied and I choose to continue services for my child, I understand that I will be responsible for fees incurred from denial date forward.

- I have read and agree to comply with the above: (sign here)_____
- I authorize payment directly to Country Kids, Inc. and authorize the release of any necessary documentation to insurance or MA for reimbursement purposes: (sign here) _____
- I have been provided with a copy of Country Kids, Inc. Privacy Notice in regard to use and disclosure of my personal health information: (sign here) _____

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CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Child's Name: _____ DOB: _____

1. Permission to Use and Disclose My Health Information. By signing this form, I give **Country Kids, Inc.** permission to use and/or disclose my child's health information to carry out treatment, payment, or health care operations as described in Notice of Privacy Practices provided to me.

2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent, **Country Kids, Inc.** will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.

I hereby give consent for use and disclosure of my child's personal health information for the purposes of treatment, receiving payment, or for health care operations by Country Kids, Inc. to the following individuals and/or institutions:

Individual or Institution Name	**Information to be Used/Disclosed**	**Purpose of Disclosure**

This authorization will be in force and effect until _____ (one year from date signed) at which time this authorization to use or disclose this protected health information expires.

_____ _____

Parent/Guardian Signature Date

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Photography Release

I hereby authorize Country Kids, Inc., hereafter referred to as "Company," to publish photographs and/or videos taken of myself and/or the minor child(ren) listed below, for use in the Company's print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Company from any reasonable expectation of privacy or confidentiality for myself and for the minor child(ren) listed below associated with the images specified above. Further, I attest that I am the parent or legal guardian of the child or children listed below and that I have full authority to consent and authorize Company to use their photograph.

I further acknowledge that participation is voluntary and that neither I nor the minor child(ren) will receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Company, its contractors, its employees and any third parties involved in the creation or publication of Company publications, from liability for any claims by me or any third party in connection with my participation or the participation of the minor children listed below.

Check one: ☐ **Consent** ☐ **Non consent**

Authorization:

Signature: _____ Date: _____
(Volunteer, Parent or Guardian)

Printed Name: _____

Address: _____

City: _____ State: ___ ZIP: _____

Relationship to minor: _____

Names/Ages of minor:
Name: _____ Age: ___

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Authorization to Provide Medical Treatment

I, the undersigned legal guardian of _____, authorize the staff of Country Kids Inc. to administer first aid/CPR in the event of accident/injury or illness. I also give permission for Country Kids, Inc. staff to seek additional medical attention from emergency health care personnel should the need arise. My hospital of preference is listed below.

Parent/Guardian Name: _____

Address (Street, City, ST, Zip): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Alternate Contact/Phone #: _____

Primary Physician's Name: _____

Physician/Clinic Phone: _____

Medical Conditions: _____

Medications Used/ Conditions Each Is Used For:

_____ _____
_____ _____
_____ _____
_____ _____

Known Allergies: _____

Preferred Hospital: _____

Parent/Guardian Signature:_____ Date:_____