2 W Vernon Ave, Phoenix, AZ 85003
P: (480) 269-4565
F: (480) 365-0111
E: Andy@Spotlightpeds.com
w: www.SpotlightPeds.com

Patient Name: ____ **Male:** ____ **Female:** _____

Date of Birth: ____________________

Reason for Referral: ____

____

Has your child received therapy before? YES or NO

If Yes, When? ______________________________________

If Yes, for what reason?

____

____

Primary Physician: ______________________________ **Phone:** ____________________ **Fax:** _______________

Referring Physician: ____________________________ **Phone:** ____________________ **Fax:** _______________

DDD Support Coordinator (if applicable):

Name: ________________________________ Phone: __________________ E-mail: ____________________________

Parent(s)/Guardian:

Mother's Name: ____

__Birth Mother __ Adoptive Mother __Step-Mother

Address: ____

City: _____________________________________ **State:** _____________________ **Zip Code:** ________________

Home Phone: ____________________________ **Cell:** ______________________ **Work Phone:** _____________

E-Mail: ____________________________________

Father's Name: ____

__Birth Father __ Adoptive Father __Step-Father

Address: ____

City: _____________________________________ **State:** _____________________ **Zip Code:** ________________

Home Phone: ____________________________ **Cell:** ______________________ **Work Phone:** _____________

E-Mail: ____________________________________

Contact Information for Caregiver who will regularly bring child to or be present for therapy:

Name: _____________________________________ **Phone Number:** ___________________________________

2 W Vernon Ave, Phoenix, AZ 85003
P: (480) 269-4565
F: (480) 365-0111
E: Andy@Spotlightpeds.com
w: www.SpotlightPeds.com

Insurance Information

Primary

Insurance Company Name:___________________________________

Type of Ins. Co.:_______________ **ID#**_______________________

Subscribers Name:_______________ **Group/Policy#**_______________

Relationship to Patient:_______________ **Subscriber's Employer:**_______________

Subscriber's SSN:_______________ **Subscriber's DOB:**_______________

Customer Service Number (on back of card):_______________________

Secondary

Insurance Company Name:___________________________________

Type of Ins. Co.:_______________ **ID#**_______________________

Subscribers Name:_______________ **Group/Policy#**_______________

Relationship to Patient:_______________ **Subscriber's Employer:**_______________

Subscriber's SSN:_______________ **Subscriber's DOB:**_______________

Customer Service Number (on back of card):_______________________

Tertiary

Insurance Company Name:___________________________________

Type of Ins. Co.:_______________ **ID#**_______________________

Subscribers Name:_______________ **Group/Policy#**_______________

Relationship to Patient:_______________ **Subscriber's Employer:**_______________

Subscriber's SSN:_______________ **Subscriber's DOB:**_______________

Customer Service Number (on back of card):_______________________

Please provide copies of insurance card(s) both front and back with this paperwork. Please notify Spotlight Staff anytime there is a change in insurance plans.

2 W Vernon Ave, Phoenix, AZ 85003
P: (480) 269-4565
F: (480) 365-0111
E: Andy@Spotlightpeds.com
w: www.SpotlightPeds.com

Developmental History

Birth History/Pregnancy:

Full Term ___Yes ___No How many weeks?______________________

Any Complications: ____

____

Birth Weight:______________ Delivery: ___Breech ___Normal ___C-Section

Early Development, Please list ages of any relevant milestones:

Rolling __________ Sitting unsupported_________ Crawling_______ Walking_________

First words______ Toilet Trained_______

Is your child taking any medications ___Yes ___No (Additional space on next page)

Name of Medication	Purpose	Dosage

Has your child ever been diagnosed with any of the following?

	Yes	No	Age
Feeding Difficulties			
Vision/Hearing Difficulties			
Lack of Oxygen			
Head Injury			
Seizure			
Coma			
Surgeries			
Allergy			
Orthopedic Limitations			

Details: ____

2 W Vernon Ave, Phoenix, AZ 85003
P: (480) 269-4565
F: (480) 365-0111
E: Andy@Spotlightpeds.com
w: www.SpotlightPeds.com

Please use this page for any additional Medication or Past Medical History Information:

2 W Vernon Ave, Phoenix, AZ 85003
P: (480) 269-4565
F: (480) 365-0111
E: Andy@Spotlightpeds.com
w: www.SpotlightPeds.com

Financial Policies

Please initial each section and sign below:

Spotlight is committed to providing the best possible care, and therefore, your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial policy, or your financial responsibility.
Spotlight will request a photocopy of the front and back of your insurance identification card and driver's license. Please update your card with any additional information your insurance company provides, which will facilitate the submission of claims on your behalf. It is your responsibility to inform us of any changes to your policy. We will bill your insurance company on your behalf as a courtesy.

_______________ **Co-Payment/Co-Insurance**

We must collect your carrier-designated co-pay at the time of service. Refusal to abide by this agreement may result in termination of your coverage. Spotlight will calculate an estimated co-payment or co-insurance based on your insurance policy. This amount will be due at the time of each appointment.

_______________ **Missed Appointments**

Patients who do not show up for an appointment, or call to cancel with less than 24 hours' notice have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patients' insurance contract, **we reserve the right to charge a $50.00 fee for no-show or same day cancelled appointments.**

_______________ **Returned Checks**

If a check is used as your form of payment, and that check is returned due to insufficient funds or the payment has been stopped, you will be charged a $25.00 fee in addition to the amount of the check.

_______________ **Insurance**

We will gladly bill and accept payment from your health insurance plan. Any amounts not covered by your insurance carrier are your responsibility.
Communication between Spotlight and our patients help us succeed in providing the best care. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations.

_______________ **Payments**

You are responsible for any amount not covered by your insurance carrier. All co-payments and deductible amounts are due at the time of service. For your convenience, we do accept all major credit cards, checks, money orders, and cash.

I have read and understand the above. I hereby authorize Spotlight Pediatric Therapy, PLLC to submit claims to my insurance carrier. I hereby authorize direct payment of benefits, otherwise payable to me, to be made payable to Spotlight Pediatric Therapy, PLLC. I understand I will be responsible for payment of any amounts not covered by my insurance carrier, including, but not limited to, co-payments and deductibles.

Signed: ____ **Date:** ______________________

2 W Vernon Ave, Phoenix, AZ 85003
P: (480) 269-4565
F: (480) 365-0111
E: Andy@Spotlightpeds.com
w: www.SpotlightPeds.com

Spotlight Policies

Please initial each section and sign below:

_________ **Cancellation / No Show Policy**

As a team we have created a plan of care for your child to meet his/her therapy needs. Following this plan of care, and attending scheduled sessions, is important in order to meet your child's full potential. If you do not abide by the plan of care, your child may be removed from their permanently scheduled appointment. The following are examples:

Your child misses two separate appointments without our office receiving a phone call.
Failure to call and cancel your appointment at least two hours before your scheduled time is considered a no-show. We have a voice mail that is checked early so you may call after hours or early in the morning.

Your child cancels three separate appointments within one quarter, without a hospitalization or a severe illness.
Please note: a rescheduled appointment within the same week is not a cancellation.

_________ **Discharge Policy**

Your child's therapy needs may change during the course of treatment. The following conditions may result in your therapist recommending discharge from Spotlight:

Plateau in function
Spotlight is committed to creating an environment that allows each child to grow. Goals are updated each quarter based on areas of need and concerns. After each quarter, progress towards these goals is discussed with caregivers, and new/updated goals are established. If a child has reached a plateau and has not made progress in 6 months, the child may be discharged.

Meeting all goals
When a child meets all of their established goals, and there are no further functional or objective goals to meet, a child will be discharged.

I, ______________________________, have read and understand the above policies and hereby request and consent to the performance of therapy, including examination and diagnosis, of my child by Spotlight Pediatric Therapy, PLLC. I consent to the treatment plan and intend this consent form to cover the entire course of treatment for my child's present condition and for any future conditions for which we seek treatment.

Patient/Guardian Signature: ______________________________________ Date: _____________________

2 W Vernon Ave, Phoenix, AZ 85003
P: (480) 269-4565
F: (480) 365-0111
E: Andy@Spotlightpeds.com
w: www.SpotlightPeds.com

Authorization for the Release of Medical Records

I hereby authorize Spotlight Pediatric Therapy, PLLC to release the medical record(s) of:

Patient's Name: ____
Date of Birth: ____

For the purpose of continued treatment and billing/re-assignment of benefits, this allows Spotlight to bill on your behalf, and for the payment to be sent directly to Spotlight, to:

Spotlight Pediatric Therapy, PLLC
2 W Vernon Ave, Phoenix, AZ 85003
Phone: 480-269-4565
Fax: 480-365-0111

Signature of Guardian: ____ Date: _____________________

Printed Name: ____

Notice of Privacy Practices

Your name and signature below indicate that you have received a copy of and/or have been directed to the Notice of Privacy Practices by Spotlight Pediatric Therapy, PLLC, on the date indicated. If you have any questions regarding the information set forth in Spotlight's Notice of Privacy Practices, please do not hesitate to ask a Spotlight representative.

Signature of Guardian: ____ Date: _____________________

Printed Name: ____

Photo Consent Release

I would like to extend permission to Spotlight Pediatric Therapy, PLLC to use my:

- Name ___Yes ___ No
- Testimonial ___Yes ___ No
- Image/photograph ___Yes ___ No

in publications and advertisements produced by or for Spotlight. I understand that these publications will also be placed on web sites managed by Spotlight for public relations and advertising purposes. I understand that the publication may appear on the Internet, the publication may appear in print, electronic, or video media, and the publication may enable readers to identify me. I understand this consent is valid until I provide written notice stating otherwise.

Signature of Guardian: ____ Date: _____________________

Printed Name: ____