High Hopes Therapy Services, Inc.
807 W. Jefferson Street, Unit U
Shorewood, IL 60404
Phone: (815) 714-2977
Fax: (815) 467-0231

Demographic Patient Information

Child's Name: ____________________ Sex: Male Female

Street Address: ____________________

City, State, Zip: ____________________

Mother's Name: ____________________ Father's Name: ____________________

Home Phone: ____________ Cell 1: ____________ Cell 2: ____________

Pediatrician: ____________________ Phone: ____________________

Pediatrician Address: ____________________

Primary Health Insurance Information

Insurance Company: ____________________ Circle: PPO HMO

ID#: ____________________ Group Number: ____________________

Name of Insured: ____________________ DOB of Insured: ____________________

Employer Name: ____________________ Employer Phone: ____________________

Employer Address: ____________________

Secondary Health Insurance Information

Insurance Company: ____________________ Circle: PPO HMO

ID#: ____________________ Group Number: ____________________

Name of Insured: ____________________ DOB of Insured: ____________________

Employer Name: ____________________ Employer Phone: ____________________

Employer Address: ____________________

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INSURANCE AFFIDAVIT AND ASSIGNMENT RELEASE

Client Name: _______________________________________ Date of Birth: ______________________

***Please read and initial to verify understanding and agreement*:**

______ Unless an *Insurance Use Exemption* is approved, I (we) consent to High Hopes Therapy Services, Inc. use of our private health insurance, assign benefits to High Hopes Therapy, and release information regarding benefit determinations, payee information, and claims. I authorize the release of any medical information necessary to process claims and payment of medical benefits.

_______ If insurance payments are made directly to me for therapy, I (we) agree to forward these payments directly and promptly to High Hopes Therapy Services, Inc. for the client listed above. I also agree to assist as needed to ensure the timely processing of any insurance claims. I (we) will notify the provider if any insurance claims are rejected by the insurance company.

_______ I agree to notify High Hopes Therapy Services, Inc. immediately with any change in private insurance plan, including a copy (front of back) of the new, valid insurance card.

_______ I understand that even though High Hopes Therapy Services, Inc. may contact my insurance company(s) for eligibility and benefit verification or to attempt to obtain an authorization to treat, I am financially responsible for any and all payments due to High Hopes Therapy Services, Inc. I understand that even though my private insurance may authorize treatment, it is not a guarantee of payment. I also understand that payment is determined by my insurance policy and is processed based upon the terms and conditions of my policy at the time of submission. I agree to pay any amounts not covered by my insurance. I understand that it is my responsibility to understand my insurance coverage, including deductible, coinsurance, copay amounts, and visit limits.

_______ If undeclared private or public health insurance is later discovered to be in effect, High Hopes Therapy Services, Inc., shall recover from the family any therapy payments for services which should have been paid by that insurance.

_______In the event that myself, my spouse, or dependents owe a balance, I agree that High Hopes Therapy Services, Inc. has the right to obtain a current credit report and I guarantee full payment of all charges unless restricted by Medicare or Medicaid.

Printed Name: ____

Signature: ____ Date: ________________________

This affidavit is valid for as long as the client receives therapy services. A photocopy of this document is as valid as the original.

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Financial Policies

High Hopes Therapy Services, Inc. requires a signed copy of this financial agreement prior to beginning services or having an evaluation.

It is the responsibility of the child's family to know and understand their insurance benefits including deductible responsibility, co-insurance, copayments, limitations/exclusions, and visit and/or dollar amount limits for therapy services.

Families should review benefit statements issued by their insurance carrier(s) which reflect payments made to High Hopes Therapy Services, Inc. to ensure accuracy of billing and to keep current regarding benefit status of submitted claims. These benefit statements will also give the family an idea of what their financial share of a service will be prior to receiving a bill from High Hopes Therapy Services, Inc.

Invoices will be sent to the family on a regular basis with all charges processed by your insurance company or for services rendered to that point if you have private pay status. All invoices should be paid within two weeks. You can pay by cash, check, or use a credit card on our payment portal at www.highhopeskids.com under the "Forms & Payments" tab. Please make sure to place your child's name in the description field under "purchase details." If at any time your invoice totals more than $500 in unpaid charges for more than 30 days, High Hopes Therapy Services, Inc. has the right to suspend all services until the account is resolved.

If a family meets any of the following criteria, High Hopes Therapy Services, Inc. will require a credit card to remain on file with our office for incurred charges: unpaid balances more than 30 days past due, unpaid no show or late cancellation charges, insufficient funds return on a check, or cash visit payments not made at time of service. Credit card information will remain secure.

If a check is returned unpaid by your financial institution, a $25 service charge will be added to your bill.

Should High Hopes Therapy Services, Inc. have to send your unpaid bill to collections, we will add a service fee of 50% to your total bill.

It is our PRIORITY to ensure that your child receives the services that they need, and we do not want financial difficulties to prevent that. High Hopes Therapy Services, Inc. will work with your family on payment plans or outside funding if cost is prohibitive to your child receiving services. PLEASE communicate with our owner, Rebecca Stonitsch, privately if this is an issue for your family. She can be reached at 815-301-7068.

My signature below verifies that I have read and agree to the above financial polices and will abide by the terms thereof.

Printed Name: ____

Signature: ____ Date: ______________________

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Child/Enrollment Guidelines and Practice Policies

Prescriptions & Paperwork:

- A physician prescription is required for all services provided. It is ultimately the family's responsibility to ensure that this is received prior to your child receiving treatment. In some cases, High Hopes Therapy Services, Inc. may assist you in obtaining this prescription. Prescriptions can be faxed directly to High Hopes Therapy Services, Inc. at 815-467-0231.
- Information may need to be collected from you regarding your insurance. We ask that you address any questions as soon as possible and return any paperwork that is needed to ensure appropriate utilization of your insurance.
- If your child is receiving additional services elsewhere, such as school or another practice, we may ask you to sign a release of information so that other providers can communicate and High Hopes Therapy Services, Inc. can provide coordinated care in the best interest of your child.

Treatment Sessions:

- Your child's treatment time includes hands on treatment, discussion of progress, parent suggestions, and training depending on your child's needs. We try to involve and inform families as much as possible. We may also contact you by phone from time to time to discuss, more in depth and privately, your child's treatment sessions.
- We do have a waiting area for parents and families. It is recommended that the parent(s) remain in the waiting room during clinic based therapy. This allows for more focused therapy time with less interruption for your child and other children receiving services. If you would like to participate directly in your child's sessions in the clinic setting, please make arrangements with your therapist individually.

Cancellations & Illness:

- If your child is ill, please contact our office at 815-714-2977 and/or your child's therapist immediately. We request that your child not return for services within 24 hours of a fever, vomiting, or beginning antibiotics.
- If your child, or close member of your family, has had head lice or scabies, please notify our office immediately so that precautions can be taken. We will work with you individually to determine the best timeframe for your child to return to therapy pending treatment.
- If there are three or more unexcused cancellations or absences within a rolling three month period, your child may lose their scheduled therapy time. Please notify your therapist, in advance, of any vacations or rescheduled sessions that you need worked out. Also note, the clinic remains open on many "school holidays", and absences from scheduled therapy times may not be excused unless prior notice is given.
- If your therapist is ill or attending a conference, she will contact you as soon as possible to notify you of her cancellation. At times, another therapist may cover in their place if available and appropriate. Your therapist will work with you, as able, if a make-up appointment is possible at a later date.

Mentoring and Supervision:

In order to provide the best possible care for your child, you child's therapist may be directly supervised during your child's session. Please understand that this is provided to all therapists regardless of experience or expertise. These observations are conducted to ensure quality of care, provide feedback and suggestions to therapists, and enhance the treatment sessions your child will receive. Please note, we are a multidisciplinary practice and have a holistic treatment approach. We may collaborate with other disciplines or providers within our practice to provide your child the best services possible!

Concerns:

If you have any questions/concerns/feedback regarding your child's therapy, progress, etc. please keep open lines of communication with us! We cannot make things better for you or your child if we are unaware of issues as they arise. We strongly feel that the family is a valued member of the child's team! The owner of High Hopes Therapy Services, Rebecca Stonitsch, is also always available to speak with you.

My signature below verifies that I have read and agree to the above financial policies and will abide by the terms thereof.

Printed Name: ____

Signature: ____ Date: ________________________