Amaryllis
THERAPY NETWORK

Infant Registration Form

Date: ____ Male / Female

Child's Name:____ **DOB:**______________________

Primary Guardian's Name(s): ____

Address:____

Phone:____ ☐ permission to leave a detailed clinical voicemail

☐ text message reminder

Email:____ ☐ email appointment reminder

Preferred language: ☐ English ☐ Spanish ☐ Other ____

Does child reside with both legal parents in the same household? ____________________________________

Who has the legal right to make medical decisions for child? ____

Secondary Guardian's Name (if applicable): ____

Address:____

Phone:____ ☐ permission to leave a detailed clinical voicemail

☐ text message reminder

Email:____ ☐ email appointment reminder

Pediatrician: ____________________________________

Clinic Name: ____________________________________

Address: ____________________________________

____

Phone: ____________________________________

Primary Insurance:

____

Subscriber DOB

____

Secondary Insurance (if applicable):

____

Subscriber DOB

____

Who referred you? ____

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Attendance and Cancellation Policy

We want your child to achieve his or her greatest potential and receive maximum benefit from therapy. Regular attendance and follow through with home program activities are key factors for improving your child's skills.

We expect that your child will attend all scheduled appointments. In the event that you need to cancel, you are required to notify **Amaryllis' front desk** and give **24 hours' notice**. If your child has multiple therapies or you have more than one child attending therapy**, please be sure to cancel all appointments that will be missed.** If your child misses more than two (2) appointments in a two-month period, we reserve the right to take them off the regular therapy schedule, unless make-up sessions are scheduled.

Illness: Please contact the office as soon as possible. You will not be charged, but the cancellation will be counted as a missed visit. Please do not bring any child, sibling or adult to the clinic if they have had a fever, pink eye, lice, diarrhea and/or vomiting in the past 72 hours. If you or your child has a cold, it is alright to attend therapy if your child feels okay, **unless** there is a fever, hacking, persistent cough or green/yellow mucus.

Weather Cancellations The clinic will be closed if Denver Public Schools are closed. These cancelled appointments will not be counted towards your missed appointments.

Late-Cancellations Fees: With cancellations made with **less than 24 hours' notice**, we are unable to offer that appointment time to other patients. Patients who have cancellations two (2) or more times in a two-month period will be placed on a floating schedule. A fee of **$50 will be charged for appointments cancelled less than 24 hours before the time of the appointment.** This fee is not covered by insurance and is due within two weeks of the cancelled appointment.

No-Show Fees: Patients who do not show up for their appointment without a call to cancel the appointment will be considered a **NO-SHOW**. Patients who no-show two (2) or more times in a two-month period will be discharged from service. A fee of **$50 will be charged for missed / NO-SHOW appointments.** This fee is not covered by insurance and is due within two weeks of the missed appointment.

The late-cancellation and no-show fees are the sole responsibility of the patient and must be paid in full within two weeks of the missed appointment. We understand that unavoidable circumstances may cause you to cancel less than 24 hours in advance. Fees in this instance may be waived with approval from the director.

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Attendance and Cancellation Policy

I acknowledge that (***please initial***):

_______ I have read the above statements and agree to all the terms and conditions contained herein.

_______ I agree to pay all fees/charges associated with the late-cancellation or no-show of any scheduled appointment.

Our practice firmly believes that a good therapist/patient relationship is based upon understanding and good communication. If you have any questions, please call our office at 303.433.0852.

Child's Name:____
(Please Print)

Parent/Guardian's Name:____
(Please Print)

_______________________________________ ______________________
Parent/Guardian's Signature Date

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Financial Policy and Agreement

Thank you for choosing Amaryllis Therapy Network. We look forward to working with you and your child to meet your child's therapeutic needs. In that effort, we have developed a financial responsibility policy to avoid any misunderstanding and to ensure timely payment for therapy services. Our practice firmly believes in honesty and transparency. If you have any questions, please call our office at 303.433.0852.

Acknowledgement and understanding of this financial policy must be signed prior to starting therapy.

PAYMENT IS DUE IN FULL AND EXPECTED AT TIME OF SERVICE
We accept cash, personal checks, debit cards, Visa and Master Card, HSA and FSA cards

By initialing all items below, you agree that you have read and acknowledge that:

_______ **Payment is required at the time services are rendered:** This includes but is not limited to: co-payments, co-insurance, non-covered and/or unauthorized services, denials for no coverage/eligibility, late-cancellation and no-show fees.

_______ **Private-Pay Accounts:** If you do not have insurance, please come prepared to pay for your visit in full. Amaryllis Therapy Network offers a discounted rate for all private-pay services paid in full on the day of the visit.

_______ **Divorce:** In the case of divorce or separation, the parent authorizing treatment for a child/children will be the parent responsible for paying for those charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_______ **Co-pays, Co-Insurance and Deductibles:** We are required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays, co-insurance and deductibles puts the responsible party and Amaryllis Therapy Network in breach of the insurance contract.

_______ **Returned Check Fee:** There is a $34 fee for any checks returned by the bank. Cash or credit card payments will be required for any account with more than one returned check fee in a twelve-month period.

_______ **Late-Cancellation and Missed Appointment Fees:** Late-cancellations and no-shows will be subject to a $50 cancellation fee. This fee must be paid in full within two (2) weeks of the missed appointment. This fee is to be paid out-of-pocket and is not covered by insurance. Please refer to our attendance policy for more details.

_______ **Change of Insurance/Change of Address:** It is the responsibility of the parents to notify the front desk as soon as possible of all insurance and address changes. Any delay in updating information may result in denied payment for services that are provided prior to receiving the updated information. Payment for denied services will be billed to you directly.

_______ **In-Network Insurance:** As a courtesy to our patients, Amaryllis Therapy Network will file claims to any insurance carrier with whom we are a participating provider. **It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier.** Please verify coverage limitations prior to your child's appointment date. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your child's eligibility and the amount that will be paid. You agree to pay any portion of the charges not covered by your insurance.

_______ **Out-of-Network Insurance:** If we are out-of-network with your insurance company, full payment of service is due the day of service. We will submit a claim on your behalf as a courtesy. Depending on your insurance plan, out-of-network benefits may be payable after your deductible is met. Some carriers will reimburse you directly, while others will reimburse the clinic. If the clinic is reimbursed, the amount will be credited to your account and future payments for services will be adjusted accordingly.

_______ **Statements:** If you have a balance on your account, we will send you a monthly statement. If your account becomes past due, we will take the necessary steps to collect this debt. Unless other arrangements are pre-approved by Amaryllis Therapy Network in writing, the balance of your statement is due within thirty (30) days from the statement date. If you feel that your claim was unfairly denied by your insurance company, it is the parent/guardian's responsibility to pursue the insurance company on their child's behalf.

_______ **Outstanding Balance:** If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, Amaryllis Therapy Network will notify you via phone, email and/or mail. If your outstanding balance is not paid in full by the statement due date, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

_______ **Collections:** If we must refer your account to a collection agency, you agree to pay all costs that are incurred. All accounts sent to the collections agency will be reported to the Credit Bureau.

_______ **Effective Dates:** Once you have signed the financial policy, you agree to all the terms and conditions contained herein, and the agreement will be in full force and effect.

By signing below, you indicate that you understand that you are ultimately responsible for the payment of your bill. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to know your benefits.

Child's Name:____
(Please Print)

Parent/Guardian's Name:____
(Please Print)

____   ____________________
Parent/Guardian's Signature   Date

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Parent Rights, Attendance Policy, and Consent for Treatment

As part of every evaluation and treatment received at Amaryllis Therapy Network, you will be treated with respect. You are entitled to information about the techniques used in your child's evaluation and treatment and an estimate of the duration and cost of therapy. You may also ask your therapist about his or her training and credentials. You have the right to seek a second opinion or to end the evaluation or treatment at any time.

In order for your child to receive the maximum benefit from therapy, it is vitally important that he or she attend scheduled appointments on a regular basis and follow the home program activities provided by your child's therapist. Amaryllis Therapy Network has a **24**-hour **cancellation policy and a $50 fee** will be charged for any missed visit within 24-hours. This fee is to be paid out-of-pocket, regardless of your insurance coverage. Please see the attached **Attendance and Cancellation Policy** for complete details.

I acknowledge the following **(*please initial*)**:

_____ I have read the above statements and agree to all the terms and conditions contained herein.

_____ I have received a copy of the 'Attendance and Cancellation Policy'.

_____ I hereby give permission for the evaluation and treatment of my child at Amaryllis Therapy Network.

_____ I understand that payment is due at the time services are rendered.

_____ I give permission for Amaryllis Therapy Network to provide me with a written copy of my child's initial evaluation.

Child's Name:____
(Please Print)

Parent/Guardian's Name:____
(Please Print)

____ ____________________
Parent/Guardian's Signature Date

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Drop Off and Pick Up Consent

Child's Name: ______________________________________ Date of Birth: ________________

This form must be presented to Amaryllis Therapy Network with a valid photo ID

I ______________________________, hereby inform Amaryllis Therapy Network that the people listed below are authorized to drop off and pick up my child from therapy sessions. Accordingly, Amaryllis Therapy Network is hereby instructed to release my child into the care of the following people:

I authorize Amaryllis Therapy Network to (***please mark all that apply***):	
☐ Release written medical information ☐ Exchange verbal information ☐ Drop off and pick up only	Name: ______________________________ Relationship to Child: ___________________ Phone Number: _______________________ Emergency Contact: ☐ Yes ☐ No
I authorize Amaryllis Therapy Network to (***please mark all that apply***): ☐ Release written medical information ☐ Exchange verbal information ☐ Drop off and pick up only	Name: ______________________________ Relationship to Child: ___________________ Phone Number: _______________________ Emergency Contact: ☐ Yes ☐ No

I acknowledge that (***please initial***):

_____ I understand that I must inform Amaryllis Therapy Network (call, leave a voicemail, send an email) of the name of the person who is dropping off or picking up or my child from therapy sessions on any day when I am not.

_____ I understand that the authorized person(s) **must be at least 18 years old** and will be asked to provide a valid photo ID.

_____ I understand that this authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Parent/Guardian's Name:____
(Please Print)

_______________________________________ _________________________________

Parents/Guardian's Signature Date