www.pediplayfamily.com
info@pediplay.com

PediPlay & MyPTIndy
6239 South East Street Suite A
Indianapolis, IN 46227-2088

REGISTRATION FORM

(Please Print)

www.myptindy.com
info@myptindy.com

PATIENT INFORMATION

Date: _____

Patient's Name: Last/First/Middle:_____ Preferred Name:_____

Birth Date: MM/DD/YY_____ Age:____ Sex: **M** **F** Social Security No:_____

Preferred Phone:_____ Alternative Phone:_____

Street Address: _____ City:_____

State:_____ Zip Code:_____ Email:_____

Primary Care Physician:_____ Diagnosis: _____

Physician Address:_____

Physician Phone:_____ Physician Fax:_____

Chose Clinic Because/Referred to Clinic By:_____ Relationship: (Circle One)

Doctor Hospital Family Friend Close to Home/Work Therapist Other_____

Other Family Members Seen Here:_____

INSURANCE INFORMATION

(Please give your insurance card & ID to the front office.)

Person Responsible for Bill:_____ Birth Date MM/DD/YY:_____

Address, if different from above:_____ Home Phone:_____

Occupation:_____ Employer:_____ Employer Phone:_____

Employer Address:_____

Is the patient covered by insurance: YES NO Subscriber's Name:_____ Subscriber's DOB:_____

Subscribers SSN:_____ Group No:_____Policy No:_____

Co-Payment: $_____ Patient's Relationship to Subscriber (circle one): SELF SPOUSE CHILD OTHER

BILLING OPTIONS

(Please check one.)

◯ I want PediPlay/MyPTIndy to bill my insurance:

☐ Anthem ☐ UnitedHealthCare ☐ TriCare ☐ Cigna ☐ Sagamore ☐ Medicaid Anthem HHW

☐ Medicaid CMCS (Traditional) ☐ Medicaid MHS Medicaid No:_____

☐ Other_____

◯ I want to Self-Pay, by self-paying I can receive a "payment at time of services are rendered discount".

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):_____

Relationship to Patient:_____ Home/Work Phone:_____ Mobile:_____

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to PediPlay or MyPTIndy (dba PediPlay). I understand that I am financially responsible for any balance. I also authorize PediPlay, MyPTIndy (dba PediPlay), or Insurance Company to release any information required to process my claims.

Patient Signature:_____ Date:_____

If under 18, Parent/Guardian Signature:_____ Date:_____

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PediPlay & MyPTIndy Patient Agreement

Our therapists seek to provide cost efficient therapeutic care for all our patients. To help us achieve this goal you, as the patient, agree to the following for the duration of your therapist-patient relationship with us.

Please realize that your insurance contract is between you and your insurance company. You are financially responsible for services rendered. However, as a courtesy, we will bill your insurance company, if you request us to do so. In these cases you agree to assign all payments to our office and authorize the collection of such insurance benefits by our office. Any co-payments are due at the time of service unless other arrangements are made in advance. To facilitate this process, you allow us time to release your medical records to your insurance company. You agree to pay any amounts not paid by your insurance company.

If we are not filing with your insurance company, payment must be made at the time of service.

If you default on paying your account and your account is assigned to an outside collection agency you will be charged the cost of collections. If your account is litigated you will be responsible for reasonable attorney fees, court fees and interest set forth by the court. Default on account will put therapy services on hold and may jeopardize your therapy time slot. Services will be restarted when a satisfactory payment plan is established and therapist caseload allows.

Any checks returned for non-payment are subject to fees set forth by state and local laws. After the second return, repayment must be made by cash or money order.

I have read and agree to the “Patient Agreement”.

_____
Signature of Patient

_____
If under 18, Signature of Parent/Guardian

_____
Print Name of Patient

_____
Date

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Patient Allergy & Medical Information

Patient Name:_____

Please list any known allergies to drugs, latex, band aids, inhalants, foods, environmental triggers or animals.

_____

_____

_____

Please list any food sensitivities or contact irritants.

_____

_____

_____

☐ No Known Allergies

Please list any known medical diagnosis, conditions, or restrictions.

_____

_____

_____

_____

Signature of Patient:_____ Date:_____

If under 18, Signature of Parent/Guardian: _____ Date:_____

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PediPlay & MyPTIndy Clinic Attendance Policy

Patients and providers are encouraged to be on time and keep all scheduled appointments. However, special circumstances may arise and appointments may be adjusted. The following attendance policy agreement is to ensure smooth delivery of services between the patient and provider.

Late Arrival:

Call the clinic immediately if you will be more than 10 minutes late to your appointment.

- It will be at your provider's discretion and dependent on the availability of the clinic if you will be able to keep your appointment.
- Any session unable to be accommodated around your scheduled day and time will be rescheduled in the same week or you may be charged a $25 "No-Show" fee.
- All subsequent "No-Show" sessions you may be charged the full therapy billing rate.

Cancellations:

- Call the PediPlay & MyPTIndy office as soon as you know you will be unable to keep a scheduled appointment date and time. Provide the day, time and reason you will be unable to keep your appointment. Leave a message on the answering machine if outside of clinic operating hours.
- Multiple no-call/no-show appointments keep the clinic from utilizing a time slot for another patient. Two no-call/no-shows may cancel an ongoing time slot.
- Please make an effort on your part to reschedule as we want you to benefit from your therapy program.

Inclement Weather:

- PediPlay & MyPTIndy clinic will be open unless emergency conditions restrict travel in which case office staff will contact you to cancel your appointment due to the clinic closing.
- Patient may cancel sessions without penalty on inclement weather days with as much notice as possible to the clinic.

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The Board of Health considers the following signs to indicate communicable disease/illness:

- Vomiting
- Diarrhea
- Rash/Swelling
- Fever Over 100 Degrees
- Sore Throat
- Red or Running Eyes

You must be symptom free for 24 hours before returning to therapy.

If you have any questions or need further clarification, please contact our office at (317) 791-9031.

I have read and understand this Clinic Attendance Policy.

Patient Signature	Date	Provider Signature	Date
If under 18, Signature of Parent/Guardian	Date		

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Lending Library Policies

Statement of Mission

We are pleased to offer our patients the opportunity to borrow resource materials that are pertinent to the continuing of your education and development. We hope you will utilize these resources as applicable to you and your family.

Policies

We appreciate your complying with the following policies. This will help us to serve your needs and the needs of other patients.

1. All materials (except specially designated books, videotaped, DVDs, and CDs) may be borrowed for a period of one week.
2. Materials may be renewed for an additional one-week period if there are no pending requests for the item.
3. Materials may be borrowed by patients currently receiving services at this clinic.
4. Borrowers are responsible for returning materials in a timely manner and in good condition. Damaged materials or materials not returned within seven days of their due date or patient discharge will be charged to the borrowers account according to the posted list price.
5. Designated materials are available for purchase through the clinic office. We will make every effort to provide patients with purchasing information on other materials as desired.

I have read and I understand the above regulations and agree to abide by all of them. I understand that any lost or damaged materials will be charged to my account.

Signature_____ Date_____

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MyPTIndy Photo Release

Patient Name (print):_____

Patient Address:_____

MyPTIndy Professional (print name/title):_____

I may be photographed for therapy documentation: YES NO

I may be photographed for teaching purposes: YES NO

I may be videotaped for teaching purposes: YES NO

I may be photographed for press release: YES NO

I may be photographed for MyPTIndy promotional material: YES NO

My photograph may be posted on the MyPTIndy website

without face showing: YES NO with face showing: YES NO

My photograph may be posted on MyPTIndy Facebook

without face showing: YES NO with face showing: YES NO

My first name may be used with photo/video release: YES NO

Comments:

_____

_____

_____

Patient Signature_____ Printed Name_____

Phone Number_____ Date_____

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PediPlay Photo Release

Patient Name (print):_____

Patient Address:_____

PediPlay Professional (print name/title):_____

My child may be photographed for therapy documentation: YES NO

My child may be photographed for teaching purposes: YES NO

My child may be videotaped for teaching purposes: YES NO

My child may be photographed for press release: YES NO

My child may be photographed for PediPlay promotional material: YES NO

My child's photograph may be posted on the PediPlay website

without face showing: YES NO with face showing: YES NO

My child's photograph may be posted on PediPlay Facebook

without face showing: YES NO with face showing: YES NO

My child's first name may be used with photo/video release: YES NO

Comments:

_____

_____

_____

_____

Parent/Guardian Printed Name Phone Number

_____

If under 18, Parent/Guardian Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

PediPlay & MyPTIndy
6239 South East Street, Suite A, Indianapolis, IN 46227

This is to acknowledge my receipt of PediPlay & MyPTIndy's Notice of Privacy Practices effective date which is October 1, 2017 an effective for the patient on the date stated below.

Date of Patient's or Personal Representative's Signature

Signature of Patient or Personal Representative

Patient's Name

Patient's Address

Name of Personal Representative
(If applicable)

Description of Representative's Authority to Act for the Patient (If applicable)

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Use of Texting

PLEASE READ CAREFULLY BEFORE SIGNING

I hereby authorize PediPlay & MyPTIndy providers and staff to contact me by texting for the purposes of scheduling appointments. Protected Health Information will not be shared via the texts.

This consent is effective from the date of my signature. I may revoke my consent in writing to PediPlay & MyPTIndy at any time.

Patient Name (Printed)

Patient Signature Date

If under 18, Parent/Guardian Signature Date

Witness Signature Date

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I,_____, the authorize students under PediPlay & MyPTIndy therapist(s) supervision

- ☐ to observe my session
- ☐ to work in my session

I may revoke this consent at any time in writing to the PediPlay & MyPTIndy office manager or director.

_____

Patient Signature Date

I,_____, the parent/guardian of _____ hereby authorize PediPlay & MyPTIndy to release and receive any necessary information regarding the treatment of my child to the following individual(s). The following individual(s) are also authorized to transport my child to and/or from therapy services.

Full Name:_____ Relationship:_____

☐ Photo or ID on File ☐ Photo or ID *Declined*

Full Name:_____ Relationship:_____

☐ Photo or ID on File ☐ Photo or ID *Declined*

Full Name:_____ Relationship:_____

☐ Photo or ID on File ☐ Photo or ID *Declined*

Full Name:_____ Relationship:_____

☐ Photo or ID on File ☐ Photo or ID *Declined*

_____

Patient Signature Date

☐ Patient Photo or ID on File ☐ Patient Photo or ID *Declined*

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Release for Appointment Reminders

I,_____(print), hereby authorize PediPlay & MyPTIndy to send me an appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Patient Contact Information:

(Please print clearly and legibly)

Email: _____

Cell Phone: _____

Patient Name (Print): _____

Signature: _____

Date: _____