Rainbow Rehab LLC
Pediatric Occupational · Physical & Speech Therapy Services

426 N. Expressway #35, Griffin, GA 30223 | Tel: (678) 429-0272 | Fax: (678) 408-9698
Facility: 141 Futral Rd, Griffin, GA 30224 and 2251 HWY 42 N, McDonough, GA 30253
Email: team@rainbowrehabllc.com | www.rainbowrehabllc.com

Welcome to Therapy

On behalf of the therapy staff, welcome to the Rainbow Rehab Therapy Department. We look forward to providing services to your child and in developing a great working relationship with the families that we serve. We will assign a specific day / time for each discipline treating your child, although this is subject to change based on many factors. Parents / caregivers are always welcome to observe and participate in treatment and advanced scheduling is appreciated although not required. Every effort will be made to accommodate parent's work schedules. Any time you have questions, concerns or simply want an update, please feel free to call or stop by our department.

Prior to starting any therapy service, we will need a copy of your child's current medical insurance card and a prescription from your child's doctor. Billing information sheets can be obtained from the Rainbow Rehab therapy staff. Our third-party billing specialist (Medbill Solutions) will verify benefits and financial arrangements can be made to satisfy deductibles and / or co-payments. Insurance billing is unique to each policy and benefits can vary greatly. While we make every effort to secure payments, parents are ultimately responsible for their child's therapy bill. Please notify us anytime there is a change in coverage or benefits.

We provide year-round therapy services including all school breaks based on both turn out and therapy staff availability. This is provided on a first come first served out-patient basis. Information regarding break-week scheduling is sent home 1-2 weeks prior to the break.

Thank you for allowing us to provide for your child's therapy needs. We look forward to serving your child.

Sincerely,
Joan Ebersole, OTR/L
Owner, Rainbow Rehab, LLC

Phone: (678) 429-0272
Fax: (678) 408-9698
Email: team@rainbowrehabllc.com

PATIENT BILLING INFORMATION

Patient Name: _____ Parent's Name: _____

Patient DOB: _____ Patient Sex: ____M ____F Diagnosis: _____

IDC Code(s): _____ Primary Care Physician: _____

Physician's Number: _____ Physician's Fax Number: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

INSURANCE INFORMATION

Insured's Name: _____ Relationship to Patient: _____

Employer: _____ Insurance Carrier: _____

Address: _____

Phone Number: _____ Policy Number: _____ Group Number: _____

Deductible: _____ Benefits: _____ Do you have a copy of the card? Y N

MEDICAID/CMO COVERAGE

Effective Date: _____ Medicaid Number: _____ CMO: Amerigroup Peach State Caresource

EMERGENCY CONTACT

Name: _____ Relationship: _____ Number: _____

ADDITIONAL PATIENT INFORMATION

Diagnosis: _____

Reason for Referral [Please include recent evaluations and/or notes]: _____

_____

Current Medications: _____

Are you receiving any other therapies at this time? If so, please describe: _____

_____

Parent Goals for Therapy: _____

_____

Policy Statement & Financial Agreement

Insurance: It is the parent / guardian's responsibility to notify Rainbow Rehab of any changes in insurance information. We require payment at time of service however as a service to our clients we will file your claims with your insurance company. We will verify your insurance benefits however this does not guarantee payment for therapy services. **Parents / Guardians are ultimately responsible for their child's therapy bill.**

Assignment of Benefits / Authorization to Release Medical Information / Consent to Treatment:
I hereby assign all medical benefits to which I am entitled to: Rainbow Rehab, LLC in the event that they file insurance on my behalf. I understand that I am financially responsible for all charges whether they are paid or not by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. Including but not limited to collection service fees, attorney's fees, and all court cost and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 20% per month for unpaid balances over (90 days old) thereby authorize said assignee to release all information necessary to secure the payments of said benefits a copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized therapy staff of Rainbow Rehab, LLC as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability of such treatment excepting acts of negligence. By signing this form, I authorize Rainbow Rehab, LLC and its billing agent, Medbill Solutions, Inc. to release my child's requested medical records to my insurance company, Medicaid, and other HIPPA compliant companies to obtain payment for services rendered to my child.

Parent / Guardian Signature: _____ Date: _____

Outpatient Therapy Scheduling and Attendance Policy

Scheduling:
Therapy sessions last either 25 or 55 minutes with the last 5 minutes designated for session review with parents. Prompt drop- off and pick up is appreciated as our appointments are scheduled back to back. While observing sessions is encouraged, parents must be available by cell phone if leaving the building. We also request that parents or caregivers return at least 10 minutes prior to the end of any session to help us stay on schedule for our next appointment.

Attendance Policy:
Children will be scheduled for outpatient therapy appointments once all required documents and insurance approvals have been received. Self- pay rates are also available. Children will be scheduled at a mutually agreed upon day and time every week. Once established, this day / time will be changed only if necessary. Reminder phone calls or texts will be sent the day prior to the appointment unless both parents and Rainbow Rehab staff agree that reminder calls can be waived. Every effort will be made to re-schedule appointments missed due to therapist absences.

Missed / Cancelled Appointments:
A minimum of 24 hour notice is requested to cancel therapy appointments. All missed appointments will be documented in the child's medical record. A "no show / no call" missed appointment adversely affects both the child and Rehab staff and may result in a discontinuation of therapy services from Rainbow Rehab, LLC. Excessive absences from scheduled therapy appointments may also be grounds for discontinuation of therapy services. Excessive absence is defined as 50% or more missed appointments in a three month time period.

Parent / Caregiver Signature:
I have read the Rainbow Rehab, LLC Outpatient Therapy Scheduling and Attendance Policy and agree to abide by the terms as outlined.

Parent / Guardian Signature: _____ Date: _____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. Rainbow Rehab has put in place preventative measures to reduce the spread of COVID-19; However, we cannot guarantee that you or your child(ren) will not be exposed to or infected with COVID-19 while attending clinic therapy sessions.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending therapy and that such exposure or infection may result in illness, hospitalization, and possible death. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at therapy.

On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Rainbow Rehab, its staff, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Rainbow Rehab therapy.

Parent / Guardian Signature: _____ Date: _____

Printed Name: _____ Name of Child: _____

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Telehealth Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

GA MED ID#: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s): _____

   _____

2. NATURE OF TELEHEALTH CONSULT: During the telehealth consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. RIGHTS: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. DISPUTES: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____ Date: _____

Printed Name: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____