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

PATIENT BILLING INFORMATION

Patient Name: ____ Parent's Name: _____________________________________

Patient DOB: ____________________ Patient Sex: ____M ____F Diagnosis: _______________________________________

Parent/Caregiver Address: ____

Home Phone: ______________________ Cell Phone: ______________________ Email: _______________________________

Physician's Name/Number: _____________________________________ Physician's Fax Number: ______________________

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

Medicaid: Number _____________________ _ Straight Medicaid _ Medicaid SSI _ Deeming Waiver

CMO: _Amerigroup _Peach State _Caresource

EMERGENCY CONTACT

Name: __________________________________ Relationship: ________________ Cell 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 ABA/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 or services for to my child.

Parent / Guardian Signature: ___________________________ Date: _____________

Outpatient Therapy Scheduling and Attendance Policy

Scheduling:
ABA Therapy sessions and scheduling will be determined by the therapists/BCBA and parents will be notified. 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. (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. 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: ____________

Photo/Video Consent Form

Consent is hereby given to Rainbow Rehab LLC. with approval of (parent/guardian)_________________________ to take videotape and photographs of (student name) ____________________________.

These photographs and videos will be used for the purpose of staff or parent training, publications, marketing, research, and participating in typically-occurring therapy activities. Rainbow Rehab LLC. will also accept any video or photographs which parents choose to provide to Rainbow Rehab LLC.

I understand that I have the right to view all videos and photographs collected by Rainbow Rehab LLC. staff. If I wish to do so, I will notify the owner in writing.

I further consent to give Rainbow Rehab LLC. the right and permission to use my name, my child's name, and/or my written or spoken words for reproduction in any publication or media prepared by Rainbow Rehab LLC.

Parent / Guardian Signature: __________________________ Date: _____________

Developmental History

CHILD'S INFORMATION

Child's Name: ____

Age: ______________________ DOB: ___________________________________ Gender: ________M ________F

Address: ____

Current School: ____

Areas of Disability: ____

____

Name/Age/Sex/Relation of Additional Children in the Household: _______________________________________

____

____

Language Spoken in Household:____

PARENT(S) INFORMATION

Father's Name: ____ Occupation: _____________________________

Phone: ____________________ Work Phone: ______________________ Email: _____________________________

Address (if different from above): ____

____

Mother's Name: ____ Occupation: _____________________________

Phone: ____________________ Work Phone: ______________________ Email: _____________________________

Address (if different from above): ____

____

Marital Status: _______Married _______Divorced ______ Separated ______ Single

EMERGENCY CONTACT(S) AND RELEASE PERSON(S)

Name: ____ Phone Number: __________________________________

Address: ____

Name: ____ Phone Number: __________________________________

Address: ____

MEDICAL AND THERAPEUTIC INFORMATION

Child's Pediatrician: ____ Number:__________________________

Address: ____

Please list Any Allergies or Reactions Your Child Has: ____

____

Complications, illnesses, infections or stress during pregnancy? Y/N (describe) __________________________

Complications during labor and delivery? Y/N (describe) __________________________

Forceps/Vacuum/C-Section? Y/N (describe) __________________________

Weeks gestation? ______________________________________

Birth Order __________ Birth Weight _________ Apgar Score at 1 Minute: ________ 5 Minutes _________

Premature/Post Mature/Full Term *(please circle one)* **Strong suck?** Y/N **Spit up frequently?** Y/N

Complications with feeding? Respiration? Sleeping? Please circle one and describe: _______________________

____

ACADEMIC INFORMATION

Please describe the type of classroom setting where your child is/was: ___________________________________

____

Does your child enjoy art or music? If so, please list the activities: ______________________________________

____

How would you describe your child? Circle all that apply.

- Usually very active
- Active sometimes but can play quietly
- Usually not active, has to be prompted
- Usually happy
- Can be moody
- Demands excessive attention
- Aggressive towards self and/or others
- Short attention span
- Lacks confidence in self
- Enjoys playing with others
- Prefers motor activities
- Prefers sit-down activities
- Separation anxiety

Does your child have outbursts or meltdowns due to anger, frustration and/or overload? Y/N

If yes, please explain and how often: ____

____

Does your child have strong fears/anxiety? Y/N Describe: ____

What kind of play or recreational activities does your child seem to enjoy the most? ____________________

____

What are his/her favorite items? ____

Does your child enjoy playing… *(please circle)*

Alone (Y/N) With younger children (Y/N) With similar aged children (Y/N) With adults (Y/N) Groups (Y/N)

DEVELOPMENTAL MILESTONES

Please note approximate age at which he/she did the following:

Sat _____ Belly Crawled _____ Crawled _____ Cruised_____

Walked _____ First Words _____ Talked _____

Undressed Self _____ Dressed Self _____ Toilet Trained _____

Tied Shoes _____ Began Pre-School _____ Snaps/Buttons/Zippers _____

Ear infections? Y/N Please describe____

Seizures? Y/N Please describe____

Injuries? Y/N Please describe____

Hospitalizations? Y/N Please describe____

Glasses? Y/N Please describe ____

Medications? Y/N Please describe ____

Preferred hand? Please circle one: Left Right No Preference Age established? ________

Has your child ever been seen by a developmental or clinical psychologist? Y/N

If so, what was the name of the professional? ______________________________ Date of last visit? _________

Has your child ever been seen by a developmental pediatrician? Y/N

If so, what was the name of the professional? ______________________________ Date of last visit? _________

Has your child ever been seen by a clinical psychiatrist? Y/N

If so, what was the name of the professional? ______________________________ Date of last visit? _________

Please indicate all therapeutic or educational interventions that your child is receiving now. Please include the name of the provider and the frequency: ____

____

**Please include a copy of IEP, IFSP, most recent therapy evaluations if transferring from another practice.*

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: ____________