



PH: 317-791-9031  
FAX: 317-791-9001

PediPlay & MyPTIndy  
1502 W. Edgewood Avenue, Suite A  
Indianapolis, IN 46217

# REGISTRATION FORM

(Please Print)



www.pediplayfamily.com  
info@pediplay.com

Date: \_\_\_\_\_ **PATIENT INFORMATION**

Patient's Name: First/Middle/Last: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

If 18 or under All Parent/Guardian's names: \_\_\_\_\_

Birth Date: MM/DD/YY \_\_\_\_\_ Age: \_\_\_\_ Sex: **M** \_\_\_ **F** \_\_\_ **Email:** \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Contact's name: \_\_\_\_\_

Alternative Phone: \_\_\_\_\_ Contact's name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Referred to Clinic by: \_\_\_\_\_ Other Family Members Seen Here: \_\_\_\_\_

**IN CASE OF EMERGENCY:** Name of local friend or relative (not living at same address): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## BILLING OPTIONS

(Please check one.)

- I want PediPlay/MyPTIndy to bill my insurance indicated below.
- I want to Self-Pay, by self-paying I can receive a "payment at time of services rendered discount".

## INSURANCE INFORMATION

\*\* Please bring your insurance card & ID to the front office at the initial evaluation \*\*

**Is the patient covered by insurance: YES \_\_\_ NO \_\_\_**

Insurance Company: \_\_\_\_\_ Patient's Relationship to Subscriber: SELF \_\_\_ SPOUSE \_\_\_ CHILD \_\_\_ OTHER \_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **Subscriber SSN:** \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Person Responsible for Bill: \_\_\_\_\_

Address, if different from above: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber: \_\_\_\_\_

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to PediPlay or MyPTIndy. I understand that I am financially responsible for any balance. I also authorize PediPlay, MyPTIndy, 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 Photo Release

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient may be photographed for therapy documentation: YES \_\_\_ NO \_\_\_

Patient may be photographed for teaching purposes: YES \_\_\_ NO \_\_\_

Patient may be photographed for press release: YES \_\_\_ NO \_\_\_

Patient may be photographed for PediPlay promotional material: YES \_\_\_ NO \_\_\_

Patient’s photograph/video may be posted on the PediPlay Website

WITH face showing: YES \_\_\_ NO \_\_\_      WITHOUT face showing: YES \_\_\_ NO \_\_\_

Patient’s photograph/video may be posted on PediPlay social media

(These may include: Facebook, Instagram, Pinterest, Twitter, and TikTok)

WITH face showing: YES \_\_\_ NO \_\_\_      WITHOUT face showing: YES \_\_\_ NO \_\_\_

Patient’s photograph/video may be posted on Gouda’s (therapy dog) social media (Facebook/Instagram)

WITH face showing: YES \_\_\_ NO \_\_\_      WITHOUT face showing: YES \_\_\_ NO \_\_\_

Patient’s photograph may be posted on PediPlay’s “Super Star Moment” Wall YES \_\_\_ NO \_\_\_

Patient’s photograph may be sent to patient’s physician as part of “Super Star Moments” YES \_\_\_ NO \_\_\_

Patient’s first name may be used with photo/video release: YES \_\_\_ NO \_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***This release may be changed at any time. Please notify PediPlay in writing of a desired change.***

**Patient/Guardian Printed Name:** \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Acknowledgement of Receipt of Notice of Privacy Practices

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This is to acknowledge that I have been offered a copy of PediPlay & MyPTIndy’s Notice of Privacy Practices, effective date October 1, 2017, and is in effect for the patient on the date signed below.

\_\_\_\_\_  
Patient’s Name:

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient’s Address

\_\_\_\_\_  
Printed Name of Personal Representative  
(If applicable)

\_\_\_\_\_  
Description of Representative’s Authority to Act for the  
Patient (If applicable)



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## Consent for Additional Persons

I, \_\_\_\_\_, the patient/guardian of \_\_\_\_\_  
 hereby authorize PediPlay & MyPTIndy to release and receive any necessary information regarding the  
 treatment of myself/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/Guardian Signature

\_\_\_\_\_  
 Date

Patient Photo or ID on File

Patient Photo or ID *Declined*



## Policies of PediPlay & My PTIndy Signature page

- ❖ I have read and accept the policies of PediPlay-MyPTIndy Patient Agreement \_\_\_\_\_ (initials)
- ❖ I understand PediPlay-MyPTIndy’s Cancellation and No-Show Policy and I understand it is my responsibility to schedule and plan appointments accordingly and adhere to the policy as stated here. \_\_\_\_\_ (initials)
- ❖ I understand PediPlay-MyPTIndy’s Illness Policy \_\_\_\_\_ (initials)
- ❖ I understand PediPlay-MyPTIndy’s Discipline Policy \_\_\_\_\_ (initials)
- ❖ I hereby authorize students under PediPlay & MyPTIndy therapist(s) supervision  
     \_\_\_ to observe my session                      \_\_\_ to work in my session                      \_\_\_\_\_ (initial)
- ❖ I hereby authorize PediPlay & MyPTIndy to send me appointment reminders via e-mail or text message using my provided information.  
     Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_ (initials)
- ❖ I hereby authorize PediPlay & MyPTIndy to e-mail or text me regarding scheduling issues, clinic announcements, and other correspondence using my provided information.  
     Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_ (initials)
- ❖ I hereby authorize PediPlay & MyPTIndy to e-mail or text me regarding promotional, informational, or other activities using my provided information.  
     Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_ (initials)

*If yes to any of the above please check preferred setting and provide preferred contact information:*

- Only email
- Only text
- Both email and text

Email address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Patient name (printed): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Patient/Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## PediPlay & MyPTIndy Policies

### **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 may 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.

### **Illness Policy**

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.

## Cancellation-No Show Policy

Your success in your therapy treatment is a direct result of regular attendance to your therapy program (not missing appointments), communicating openly with your therapist, and following your home program as instructed by your therapist. PediPlay and MyPTIndy strive to provide the highest quality of care while attempting to accommodate each patient's schedule. We provide each patient a scheduled appointment with their therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment program is paramount to your care and recovery.

While we are sensitive to emergency situations; cancellations, tardiness and absences reduce our ability to accommodate the scheduling needs of all our patients. As such, we request your full cooperation with the following company policy:

### **AT LEAST 24-HOUR PRIOR NOTICE IS REQUIRED FOR CANCELLATIONS**

We cannot guarantee that we will be able to treat you if you are more than 15 minutes late to your appointment. Similarly, you may have to wait until your scheduled appointment time if you arrive early.

#### **Please be advised; if any of the following occur:**

- *Three consecutive missed or cancelled appointments. (Not appointments cancelled by therapist)*
- *Two no shows (i.e. missed appointments without a phone call to cancel).*
- *Erratic and/or inconsistent attendance (including late arrivals to therapy).*

#### **Then the result may be one of the following:**

- *Appointment time rescheduled to a different day or time of the clinic's discretion.*
- *Call-in appointments only. An appointment where the patient calls the day they are wanting to be seen for therapy to see if an appointment is available.*
- *Discharge from therapy.*

## Discipline Policy

We respect each family's right and understanding of their child to parent and discipline in the way that works best for their family. We believe children learn best with logical consequences and infuse that skill building into sessions.

Like all early childhood settings who receive any state or federal funds, we are a state mandated reporter and are not allowed to use any form of physical discipline or allow physical discipline in our facility or parking lot.

Please understand our need to be sure each of our families understands our legal and philosophical need to ensure physical discipline does not occur within or around our facility.

Should you have any concerns or wish to discuss this further, please ask to speak with our clinic director.



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## **Student/Intern Observation Release**

PediPlay/MyPTIndy is a teaching facility. There are often students and/or interns that may be completing their coursework under the direction of your PediPlay therapist. If you consent to student/intern observations, you are authorizing students under PediPlay & MyPTIndy therapist(s) supervision to observe in sessions or to work in sessions. You may revoke this consent in writing to the PediPlay & MyPTIndy at any time.

## **Appointment Reminders**

If you approve of appointment reminders with PediPlay & MyPTIndy you may choose email or text messaging as reminder options. If you agree to these forms of communication, you are accepting understanding that these are sent unencrypted. Reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location. You may revoke this consent in writing to the PediPlay & MyPTIndy at any time.

## **Use of Texting**

If you approve of texting, you are hereby authorizing PediPlay & MyPTIndy providers and staff to contact you by texting for the purposes of scheduling appointments, clinic closures, or other correspondence regarding care. You may revoke this consent in writing to the PediPlay & MyPTIndy at any time.



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## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state, and local law.

We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/Notice of Privacy Practice.doc officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these



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purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorizations.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communication of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations
- The right to access, inspect, and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting or disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices, please contact: PediPlay LLC**

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

877-696-6775 (toll free)