4362 Northlake Blvd., Suite 105 & 107
Palm Beach Gardens, FL 33410
561-625-6860 phone
561-625-6859 fax
www.youngbodyrehab.com
youngbodyrehab@gmail.com

CLIENT DEMOGRAPHIC January 2023 Date: _____

Child's Name: _____ DOB: _____

Mailing Address: _____

City/State/Zip: _____

Parent Name: _____ Best Contact #:_____

E-Mail:_____

Name of Insurance: _____ Name of Insured on policy (parent): _____

ID# _____Group # _____ Insured Parent DOB: _____

Primary Care Physician: _____ Physician phone #:_____

Primary Care Physician Address: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES 2023

I certify that I have read the Young Body Rehabilitation, Inc. Notice of Privacy Practices. Young Body Rehabilitation, Inc.'s (YBR) Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a copy by contacting the office.

The Notice also describes my rights and YBR's duties with respect to my protected health information.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

My child's primary care physician will receive a copy of physical therapy evaluations & assessments.

The following is a list of **other** physicians and health care professionals authorized to receive and provide copies of medical reports relating to application of physical therapy services and plan of treatment.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

INFORMED CONSENT/PHOTO RELEASE

I hereby consent and authorize initiation of therapy and continuation of therapy intervention at Young Body Rehabilitation, Inc., for my child, and understand the benefits and risks associated with such intervention. Young Body Rehabilitation, Inc. may also attain and maintain photographic images of my child for the purpose of documentation of therapy progress, individual home exercise program planning, and/or basic medical diagnosis. I give full permission to Young Body Rehabilitation, Inc., its employees, and its staff to obtain photographs of my child for this use. Any photographs will remain part of the medical record, subject to healthcare privacy rules and regulations.

PATIENT FINANCIAL AGREEMENT/RELEASE OF INFORMATION AND BENEFITS

I hereby authorize Young Body Rehabilitation, Inc. to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine these benefits payable. I request that payment of authorized benefits be made payable to Young Body Rehabilitation, Inc. on my behalf.

1. Young Body Rehabilitation, Inc. participates with Florida Medicaid. By contract, covered charges will be paid directly to us. Any applicable co-insurance payments are due at the time of service. Under the Medicaid program, YBR is a participating provider for Prestige--Amerihealth/Caritas, straight Medicaid managed by EQHealth, and Sunshine/ CMS line of Medicaid. YBR is a participating provider with all other Medicaid HMO plans only for children enrolled in the Early Steps Program.

2. Young Body Rehabilitation, Inc. participates with most PPO programs as an out of network provider; participants are responsible for their co-payments at the time of service. Points of service (POS) participants are also responsible for obtaining a referral from your primary care physician prior to your visit.

3. Young Body Rehabilitation, Inc. participates with Blue Cross Blue Shield as an out of network provider. I understand that if I receive payment directly from this insurance. I accept responsibility for promptly remitting full payment inclusive of co-insurance to Young Body Rehabilitation, Inc.

4. Young Body Rehabilitation, Inc. participates with the Early Steps Program/Part C of Palm Beach County. I understand that I am responsible for payment of any services rendered that are not authorized on the Individualized Family Support Plan.

5. A $50.00 fee will be charged to all patients for any returned checks.

6. I understand that I am financially responsible for all non-covered charges incurred on my behalf.

7. A copy of this agreement may be used in place of the original.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority