Updated 08/23/2017

Cancellation/No Show Policy

Cowtown Pediatrix Clinic is implementing a new cancellation and no show policy effective immediately.

Please cancel your appointment 24 hours in advance or you will be charged a flat fee of $25.00. This fee will not be billed to insurance. *

You will not be charged if you cancel at least 24 hours before your appointment time.

There will be a $50.00 penalty for No Shows (not calling to cancel)

After 3 No Shows, or after the third cancelation in a row, your child will be taken off the schedule.

*We understand there are emergencies and sick children. We are willing to work with you. The first time to cancel within 24 hours will be a freebie. After that, this policy will be implemented.

I have read and understand the above policy.

_______________________________________ ___________________

Signature Date

CONSENT FOR TREATMENT FORM

Child's Name: ____

I give permission for the staff occupational therapists at Cowtown Pediatrix Clinic (CPC) to evaluate and treat my child. When OT interns are rotating through CPC, I understand that my child may be evaluated and treated by an OT intern. I understand that my child's clinical needs will always be under the supervision of a licensed OTR from CPC. I also understand that the level of independence the OT intern has with my child is directly related to his/her level of clinical development within his/her fieldwork experience. In addition, I understand, while CPC strives to be consistent, that due to availability in the schedule, the therapist that performs the evaluation may not necessarily be my child's ongoing therapist.

_______________________________ _______________________________

Parent/Guardian Signature **Date**

I understand that all information surrounding my child is private and confidential. I also give permission for email correspondence with CPC regarding my child.

_______________________________ _______________________________

Parent/Guardian Signature **Date**

I authorize CPC to discuss my child's care, if applicable, with other team members, such as doctors, school, speech therapist, etc.

_______________________________ _______________________________

Parent/Guardian Signature **Date**

RELEASE FORM FOR PHOTO/VIDEO USE

I authorize CPC and/or Cowtown Kids Connections preschool group, to use my child's photo(s)/videos in printed materials and/or digital format for the use of educational or marketing purposes for the clinic. I understand that I will be notified before the use of the photo(s) and/or video(s).

_______________________________ _______________________________

Parent/Guardian Signature **Date**

4011 Benbrook Highway, Suite C FORT WORTH, TX 76116
Office: 817-386-5500 FAX: 817-349-9941 office@cowtownpediatrixclinic.com

Enclosed is the New Patient Intake Form. Please read the information carefully, fill out the documents and return to us so we can start the insurance benefits check process. **Please call your pediatrician's office and ask for a prescription for OT to evaluate/treat services.** This can be faxed directly to Cowtown Pediatrix Clinic @ 817-349-9941. Insurance companies require the prescription for reimbursement purposes. Cowtown Pediatrix is in network with Blue Cross Blue Shield, but out of network with all other insurance companies including Tricare/Military. We are also not currently able to accept Medicaid clients. You will need to pay your co-pay or in-full for each appointment in accordance with the terms of your contract with your insurance company and benefits policy. Your child's evaluation will last approximately 1-2 hours. Your therapist will schedule a follow-up appointment to discuss the evaluation and treatment options with you. Once we receive your insurance information, we can schedule our child's evaluation.

Please fill out the following information and fax or email back to number at the bottom of the page.

Patient Name: ____

Address: ____

City: ______________________State: ___________ Zip Code: _____________

Phone #: ____________________________________

Insurance Information

Patient Date of Birth: ________________ Insurance Company Name: _________________
Member ID #: ____________________ Group #: ___________________
If Military: Rank _______________ Active Duty ________ Non Active Duty _________
Member Name: ______________________ Member Date of Birth: ________________
Reason for OT evaluation/primary concerns:
____
____
Diagnosis (if any): _____________________________
Pediatrician: _____________________________

Thank you,
Cowtown Pediatrix Clinic,
LLC Sue Khammar, OTR

4011 Benbrook Highway Suite C Fort Worth, TX 76116 Phone: (817) 386-5500 Fax: (817) 349-9941
email: office@cowtownpediatrixclinic.com