# NEW CLIENT INFORMATION

*Today's Date:* ____________________

Patient's Name: ________________________________ Date of Birth: ____________________
Parent(s) or Guardian(s): ________________________________________________
Address: ________________________________________________________
City: ________________________________ Zip Code: ____________________
Home Phone Number: ________________________ Mobile Phone: ____________________
Father's Employer: ________________________ Work Phone: ____________________
Mother's Employer: ________________________ Work Phone: ____________________
E-Mail: ________________________________
In case of emergency, contact: ________________________ Phone: ____________________

Referred by: ________________________________________________________
Address: ________________________________ Phone: ____________________

**MEDICAL INFORMATION:**
Patient Diagnosis: ________________________________________________
Why do you want an Occupational Therapy evaluation for your child? ____________________
________________________________________________________________
Medications: ________________________________________________________
Does your child have seizures?____________ Has your child been hospitalized? ____________
Has your child ever had a head injury? ____________ Does your child have vision problems? ____________
Does your child have hearing problems? ____________ Does your child have any allergies? ____________
If you answered *yes* to any of the above questions please explain: ____________________
________________________________________________________________
Are there any specific limitations or precautions that would pertain to therapy (i.e. physician's precautions) ____________
________________________________________________________________
Is there anything the therapist needs to know about your child? (i.e. behavior, sensitivities, fears, etc.) ____________
________________________________________________________________

**BIRTH HISTORY:**
Was the pregnancy normal?____________ Did the pregnancy go full term?____________
Was the delivery without complications?____________ Child's birth weight?____________
If you answered *no* to any of the above questions please explain: ____________________
________________________________________________________________

**DEVELOPMENTAL HISTORY:** At what age did your child first…?
Roll over:__________ Sit alone:__________ Assume hands and knees:__________
Crawl:__________ Stand:__________ Walk alone:__________
Eat baby food:__________ Say first words:__________ Show interest in toys:__________

CURRENT GRADE:____________________SCHOOL:____________________________

Please share any additional concerns you have regarding your child: ____________________
________________________________________________________________

# INSURANCE INFORMATION

Insurance Co: ____________________________________________

Address: ______________________________City______________________

Zip Code: ________________Phone #______________________________

Policy/ ID #: ______________________Group: ______________________

Name of Patient: _________________________Date of Birth:______________

Name of Insured: _________________________Date of Birth:______________

Secondary Insurance: ______________________________________

Policy/ID #: ______________________ Address: ______________________

Phone: __________________

I understand that regardless of insurance coverage I am legally responsible for all fees due for services received at Pediatric Therapy Solutions, PLLC.

Signature: ___________________________________Date: ______________

Printed Name: ____________________________________________

# INFORMED CONSENT FOR EVALUATION AND TREATMENT

I ______________________________________, hereby consent to evaluation and/or treatment of myself/my child by Pediatric Therapy Solutions, P.L.L.C.. I agree, should I present my child for evaluation and/or treatment that I have legal authority to do so. I understand it is my responsibility to maintain scheduled appointments, provide payment for services rendered, and provide an accurate and complete account of current and past evaluations, treatment, symptoms and complaints.

**Confidentiality Disclosure:**

I understand the confidential nature of my records *may not be protected* under the following circumstances:

Suspicion or evidence of child abuse or neglect; Immediate danger to myself or others; Need for hospitalization; In the event it becomes necessary to submit my charges to a collection agency for non-payment; Legal cases in which I use my psychological status as a defense or mitigating circumstance; and cases involving health professionals who may be impaired or violating licensing statues or rules.

I authorize release of only necessary information to other providers employed or contracted by Pediatric Therapy Solutions, P.L.L.C. for the purpose of ; assisting in the provision of appropriate diagnosis, treatment and care, and/or purpose of consultation and supervision.

**Release of Information to Insurance**

I understand Pediatric Therapy Solutions, P.L.L.C. may file insurance claims. If I request Pediatric Therapy Solutions, PLLC to file an insurance claim on behalf of myself, I understand my insurance company may request my medical records. In order to expedite claims, I authorize release of a copy of the original complete record to any request for documentation by the insurance carrier or representative.

By signing below, I indicate my understanding of the above, agreement to the above terms and conditions, and the above has been explained to me in terms I understand. By signing below I also indicate I have asked any questions I might have about the above terms and conditions and my questions have been answered.

I agree to evaluation and treatment and agree to the above terms and conditions, and release of information.

Signature ____________________________________________ Date ______________________

Signature of Witness __________________________________

OFFICE: 9821 E. Bell Rd., Suite 100, Scottsdale, AZ 85260 BILLING: 1215 W. Barrow Dr., Chandler, AZ 85224 WWW.PEDIATRICTHERAPYSOLUTIONSAZ.COM
PHONE: (602) 697-3457 FAX: (480) 777-2355 EMAIL: pedtherapy@cox.net

# AUTHORIZATION FOR RELEASE OF INFORMATION

Client: ______________________________________________ Date of Birth: ____________________

Parent Name: ________________________________________________________________________

I, __________________________________, hereby authorize ________________________________

________________________________

________________________________

To release the information described below to:

Person and agency, address: _________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Check all that apply:

- ☐ Occupational Therapy records
- ☐ Physical Therapy records
- ☐ Speech Therapy records
- ☐ Other ________________________________________________________________________
- ☐ Psychological records
- ☐ Medical records
- ☐ Vision records

* Records include but are not exclusive to; evaluations, treatment plans, progress notes, etc.

Purpose for Disclosure: ________________________________________________________________

____________________________________________________________________________________

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has already been taken. This consent will expire automatically twelve months from the date on which it is signed. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purpose of this disclosure.

_____________________________________________________ ___________________________

Signature of Parent Date signed

**Notice to Recipient:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

**Effective date: 3/17/2007**

# NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.**

**Please review this notice carefully.**

**A. Our commitment to your privacy:**
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

**The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. 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.**

**B. If you have questions about this Notice, please contact:**
Joann McFee, 9821 E. Bell Rd, Scottsdale, AZ 85260, 602-697-3457**.**

**C. We may use and disclose your PHI in the following ways:**
The following categories describe the different ways in which we may use and disclose your PHI.
**1. Treatment**. Our practice may use your PHI to treat you. Treatment means providing, coordination, or managing health care and related services by one or more health care provider. Additionally, we may disclose your PHI to others who may assist in your care. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
**2. Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

NOTICE OF PRIVACY PRACTICES, Cont.

**3. Health care operations**. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
**4. Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
**5. Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the office for treatment. In this example, the baby sitter may have access to this child's medical information.
**6. Disclosures required by law**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

**D. Your rights regarding your PHI:**
You have the following rights regarding the PHI that we maintain about you:

**1. Confidential communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **[**Joann McFee, 9821 E. Bell Rd, Scottsdale, AZ 85260, 602-697-3457**]** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
**2. Requesting restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **[**Joann McFee, 9821 E. Bell Rd, Scottsdale, AZ 85260, 602-697-3457**]**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

**3. Right to file a complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Department of Health and Human Services. To file a complaint with our practice, contact Joann McFee, 9821 E. Bell Rd, Scottsdale, AZ 85260, 602-697-3457. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.
**4. Right to provide an authorization for other uses and disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Joann McFee, 9821 E. Bell Rd, Scottsdale, AZ 85260, 602-697-3457.

For more information about HIPPA or to file a complaint contact the US Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, 877-696-6775

I acknowledge that I have received a copy of, read and understand the NOTICE OF PRIVACY PRACTICES, effective 3/17/2007 for Pediatric Therapy Solutions.

________________________________________

Patient Name

________________________________________ ________________

Parent or Guardian Date

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