1270 McConnell Dr, Suite B
Decatur GA 30033
Phone: 770-892-OTPT (6878)
Fax: 404-521-4121
Email: admin@ontargetpediatrictherapy.com

Welcome to On Target Pediatric Therapy, LLC. We look forward to working with you and your child. Please fill out the following pages to the best of your ability. This paperwork will remain confidential. If you feel uncomfortable with a question below or are unsure how to answer it, please let us know prior to your initial treatment session.

<u>Please bring the following items to your child's first session: pediatrician's prescription for therapy, child's insurance card and your ID</u>

Some things to keep in mind for your first session/evaluation:

1. Please come prepared to let the therapist know what your goals for your child are. As the child's parent, you see what his/her daily challenges are!
2. Bring socks. Our rule is no shoes in the therapy room!
3. Make sure your child is dressed in comfortable clothing that he/she can move in easily.
4. Don't feed your child too much before the appointment. We'll likely be doing swinging, spinning and lots of movement.
5. Please reschedule if your child is sick. We have a lot of children come into the clinic and while we do our best to clean the equipment, we wouldn't want other children to catch any germs.
6. While we invite the parent/parents of children to join us in the therapy room for both the evaluation and treatment sessions, please refrain from bringing your child's siblings into the therapy room. It can be quite distracting to both your child and the therapist and may present safety issues. During therapy sessions and the observation segment of the evaluation, we ask that you refrain from instructing or giving feedback to your child as we are using this time to observe what your child does independently.

Thank you so much for your understanding. We look forward to working with you and your child.

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Patient Information:

Patient Name ______________________________ Preferred Name (if different)____________________

Date of Birth _____________________ Child's Age __________________ Gender__________

Address of Patient ____

City_________________________________ State____________ Zip code________________

Guardian #1 name ___________________________Guardian #2 name____________________________

*Who has legal custody of the child? ____

Address of Parent or Guardian (if different from above)

____

Home Phone ____________________Work Phone_________________Cell Phone __________________

Can we leave a detailed message on these phone numbers regarding your child's therapy and/or payments? ____

Can we send text messages to your phone (appointment reminders, etc)? **YES** **NO** (Circle One)

If so, what is your cellular provider? (ex. ATT, Verizon, etc)_______________________________________

Email Address 1:____

Email Address 2:____

Please be aware that e-mail is not a completely secure method of communication.

I acknowledge that staff member has my permission to correspond via that email address.

Guardian Name:_________________________________ Relationship to child: ____________________

Signature: ____________________________________ Date: _________________________________

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Background Information

My child is here for an OT/PT/Speech (circle all that apply) evaluation

Has your child been evaluated for the above service within the last year? __________________________

**If yes please bring a copy of the evaluation to the first treatment session*

Does your child currently receive any other services (OT, PT, Speech, Social, Psych) ? ________________

Does your child have a current IEP/IFSP? _______________ (If so, please provide us with a copy)

Has your child had a hearing screening (if coming if Speech Evaluation? ____________ (If so, please provide us with a copy)

Does your child wear glasses? ____

Has he/she had his/her hearing checked? ____

Referring Pediatrician _____________________________ Phone number ____________________________

Primary Care Physician_____________________________ Phone number____________________________

Name of Physician's practice:_______________________________________

If you switch Physicians, please inform the office as we send therapy records to your referring physician.

Please be aware that by signing below you are expressing your understanding that we will send any records to the physician on file.

Who referred you for this evaluation and why? ____

____

What are your child's strengths? ____

____

What kind of interests and activities does your child enjoy? ______________________________________

____

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As a parent, what are your biggest concerns regarding your child's development? Examples may include: Activities of daily living (such as eating, dressing, etc.), sensory processing, motor, play, speech output, etc. ____

____

Does your child have any significant medical history or complications during pregnancy/birth? If yes please explain ____

Does your child have a specific diagnosis? ____

Does your child have any allergies? ____

At what age did your child reach the following milestones:

Rolling _________ Sitting ________ Walking ______ Talking ___________

What grade is your child in? Is this his/her first time in that grade? ____________________________

Does he/she have any special educational accommodations? _________________________________

How many teachers and assistants are present in his/her classroom? ___________________________

How many children are in his/her class? ____

Communication between our therapists and child's teachers, other therapists and other professionals involved in your child's care is often beneficial. If you sign below, you are allowing our therapists to communicate with child's teachers, psychologists, case workers, other physicians or other members of your child's team. Please add any comments below if you have any specific requests.

Signature: ____ Date________________________

____

____

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Health Insurance Billing Consent Form

Health Insurance Company: ____

Member ID ___________________________________

Phone number _________________________

Name of Primary Insured ______________________________ SS # of Primary Insured ______________

Insured's date of birth ______________________

Insured's address (if different from above) ____

Insured's Phone ______________________ Employer _____________________________________

Insurance Benefits Phone number (on back of insurance card) _________________________________

Do you have secondary insurance? If yes please provide information below.

____

I consent to necessary examination procedures and/ or treatment for my child by a member of the On Target Pediatric Therapy Team.

I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to On Target Pediatric Therapy LLC for services provided and claimed.

Guardian Signature ____________________________________Date ___________________________

I have been offered a copy of On Target Pediatric Therapy's Notice of Privacy Practices, have reviewed it and agree to it.

Guardian Signature ____

Guardian Name ___________________________________ Date ___________________________

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NOTICE OF PRIVACY PRACTICES

The notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPA). It describes how we may use or disclose your child's protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and or refuse the release of specific information outside of the system except when the release is required or authorized by law or regulation.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. The intent is to make you aware of the possible uses and disclosures of your child's protected health information and your privacy rights. The delivery of your child's health care services will in no way be conditioned upon your signed acknowledgment.

Who will follow this Notice

This notice applies to all therapy services provided by On Target Pediatric Therapy LLC. It also applies to office and billing personnel.

Our responsibility regarding Protected Health Information

Your child's 'protected health information' is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your child's past present or future physical or mental health or condition and related health care services. We are required by law to do the following:

- Make sure that your child's protected health information is kept private
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your child's protected health information
- Follow the terms of the notice currently in effect
- Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about your child as well as any information received in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the top of this notice.

Our System

On Target Pediatric Therapy LLC works with several agencies and referral sources. Your child's health information will be shared in the following manner:

1. Treatment - We will use or disclose your child's protected health information to provide, coordinate or manage your child's health care and any related services. This includes disclosure to your physician or other health care providers who will become involved in your child's care
2. Within our office for administrative activities, quality assessment, oversight and peer review.
3. With our billing personnel and as necessary to obtain payment for your health care services.
4. With your insurance company or other payers as required for payment.
5. With the referring agency and case manager, if applicable.
6. With any provider, school or agency with your written consent. You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

Required by Law

We may use or disclose your child's protected health information if law or regulation requires the use or disclosure. We will notify the appropriate government authority if we believe the patient has been a victim of abuse, neglect or domestic violence.

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Health Oversight

We may disclose protected health information to a health oversight agency for activities authorized by law such as audits, investigations and inspections. These health oversight agencies may include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings

We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful purposes.

Parental Access

We may disclose your child's protected health information to parents, guardians and person's acting in similar legal status.

Uses and Disclosure of Protect Health Information Requiring your Permission

In some circumstances you have the opportunity to agree or object to the use or disclosure of all or part of your child's protected health information. Since this service may be provided in a natural environment, others present during a session such as family members, friends or day care providers may hear health information regarding your child. Please notify your therapist if you do not want your child's protected health information to be discussed.

Your rights regarding your Child's Health Information

You may exercise the following rights by submitting a written request to the On Target Pediatric Therapy office.

1. You may inspect and obtain a copy of your child's protected health information that is kept as a part of medical and billing records.
2. You may ask us not to use or disclose any part of your child's health information for treatment, payment or health care operations. Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm your child.
3. You may request that we communicate with you using alternate means. We will not ask the reason for your request and will accommodate reasonable requests when possible.
4. If you believe that the information we have about your child is incorrect or incomplete you may request an amendment to your child's protected health information as long as we are responsible for and maintain this information. While we will accept your requests for amendment, we are not required to agree to the amendment.
5. You may requests that we provide you with an accounting of the disclosures we have made of your child's protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. This disclosure must have been made after September 1st, 2015, and no more than 6 years from the date of the request. This right excludes disclosures made to you or authorized by you to family members or friends involved in your child's care, or for notification. The right to receive this information is subject to additional exceptions, restrictions and limitations as described earlier in this notice

Federal Privacy Laws

This notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing policies and this notice of how we will use and disclose your child's protected information.

Complaints

If you believe these privacy rights have been violated, you may file a written complaint with the Department of Health and human Services. No retaliation will occur against you for filing a complaint.

This notice is effective in its entirety as of November 1st 2015.

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Parental Presence During Sessions

Children requiring therapy benefit greatly from an alliance between the parents and therapist. Most therapy sessions include demonstrations of techniques for parents so they can follow through with observed and recommended activities. Your child requires your assistance in order to progress.

If your regular child care provider will be accompanying the child to his/her therapy session, you may provide permission for that provider to be present during therapy sessions.

I give ______________________________ permission to attend therapy sessions with my child. The therapists at On Target Pediatric Therapy have my permission to provide any relevant medical information necessary to provide service and instruct him/her regarding home exercise programs.

Guardian Signature__________________________

Date___________________________

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Cancelation/Late Arrival Policy

At On Target Pediatric Therapy LLC we value your time. Should a situation arise where we cannot keep to your scheduled appointment time, we will do our best to inform you of the scheduling change in a timely and efficient manner.
Likewise, we ask that you honor the time and schedule of other clients and our therapists by confirming all cancellations at least 24 hours before your scheduled appointment. Failing to do so will result in a non refundable $50 cancellation fee.

If you arrive for your session more than 10 minutes late, you may be charged a late fee of $50. Additionally, the session may need to be rescheduled based upon the discretion of On Target Pediatric Therapy.

If you have failed to show up for your scheduled session and/or cancelled less than 24 hours in advance three times, we reserve the right to cancel all future appointments. Additionally if you cancel with more than 24 hours notice or by text reminder for 25% or more of your sessions over a two month period, or 50% of sessions over a one month period we reserve the right to cancel all future appointments as therapy slots are in high demand and we are unable to reserve the spot for families who are not consistently attending appointments.

If your child is taken off the schedule due to multiple no shows or cancellations, in order to be allowed back on the schedule (at the discretion of staff) we charge a $50 reinstatement fee.

I have read and agree to On Target Pediatric Therapy's cancellation policy.

Guardian Name ______________________________ **Date**_________________

Signature ___________________________________

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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

We ask your cooperation by coming to the office prepared to pay for services rendered. While we do our best to contact your insurance provider to acquire an understanding of your benefits before treatment is rendered, it is your responsibility to confirm these benefits with your insurance. Please discuss any questions regarding applicable copayments, co-insurances, or deductibles with office staff at least 1 business day prior to your appointment.

If you switch insurance, you are required to let the office know no less than 2 weeks prior to the change.

I hereby authorize the release of any medical information necessary to process insurance claims.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to On Target Pediatric Therapy, LLC (OTPT) for any and all therapy services that have been or will be rendered or provided.

I Understand that I am financially responsible for all charges whether or not paid by my insurance and that copayments and deductibles are due at time of service unless I am told otherwise by office staff.

Signed this ______ day of _________________, 20 ____.

(Signature) X__________________________________

(Printed name) _________________________________

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Waiver and Release of Liability

In agreeing to receive care provided by On Target Pediatric Therapy LLC and to use the facilities provided therefore located at 1270 McConnell Dr, Suite B Decatur GA 30033, I agree as follows: I fully understand and acknowledge that (a) the activities in which my child will engage as part of the treatment provided by On Target Pediatric Therapy and the therapy activities and equipment he/she may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in use of any equipment and participation in these activities; (b) participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of On Target Pediatric Therapy LLC, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my child's participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of On Target Pediatric Therapy LLC, or by any other person. I, on behalf of my child, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify On Target Pediatric Therapy LLC and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of the use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of On Target Pediatric Therapy LLC.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE ON TARGET PEDIATRIC THERAPY LLC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Guardian name (print) ______________________________ **Guardian date of birth** ______________

Signature ____ **Date** _________________