TheraPeds
Pediatric Therapy

ST/OT Intake Forms

HIPAA POLICY
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) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. 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. 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.Protected health information (PHI) is part of your medical care, and can be used or disclosed as follows:

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

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 be an internal quality assessment review.

Appointment Reminders. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits or services that may be of interest to you.

Other Uses and Disclosures. We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- As Required By Law. We may use or disclose your information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required and permitted by law, of any such uses or disclosures.
- Public Health. We may disclose your information for public health activities to a public health authority permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your information, if directed by the public health authority, to another government agency collaborating with the public health authority.
- Communicable Diseases. We may disclose your information, if authorized by law, to a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading the disease.

o Health Oversight. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies may include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
o Abuse or Neglect. We may disclose your information to a public health authority that is authorized by law to receive reports of child abuse or neglect. We may disclose your information if We believes that you have been a victim of abuse, neglect or domestic violence to the appropriate governmental entity or agency. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
o Food and Drug Administration. We may disclose your information to a person or company required by the FDA to: report adverse events, product defects or problems, or biologic product deviations; track products; recall a product; to make repairs or replacements; or to conduct post marketing surveillance.
o Judicial or Administrative Proceedings. We may disclose your information when required for judicial or administrative proceedings, such as in response to a subpoena or discovery request if certain conditions are met.
o Law Enforcement. We may also disclose information for law enforcement purposes, if applicable legal requirements are met. These law enforcement purposes include (1) legal processes or as otherwise required by law, (2) limited information requests for identification and location purposes, (3) information pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, and (5) in the event that a crime occurs on our premises.
o Research. We may disclose your information for research, subject to certain conditions. All research projects, however, are subject to a special approval process. In some instances, the law allows us to do some research using your PHI without your approval.
o Criminal Activity. Consistent with applicable federal and state laws, we may use or disclose your information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your information if it is necessary for law enforcement authorities to identify or apprehend an individual.
o National Security. We may disclose your information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
o Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance with the law.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures not provided for in this notice 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 authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

o You have the right to inspect and copy most of your protected health information for as long as we maintain it as required by law. All requests for access must be made in writing. We may charge you a

nominal fee for each page copied and postage if applicable. You also have the right to ask for a summary of this information. If you request a summary, we may charge you a nominal fee.

o The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure 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.

o The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

o The right to inspect and copy your protected health information. The right to amend your protected health information. The right to obtain a paper copy of this notice from us upon request.

o The right to have us amend our records of your information about you. We may refuse to amend information that is accurate, that was created by someone else, or is not disclosable to you.

o The right to see an account of certain disclosures of your medical information by us, which includes the purposes and recipients of the information.

This notice is effective as of July 28, 2020 and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Contact. If you have any questions or comments about this Notice, or to request a paper copy of it, you can write our Privacy Officer at renee@therapedsohio.com.

Please contact the following for more information regarding your rights under HIPAA or to make a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

TheraPeds
Pediatric Therapy

Payment Policy & Fee Schedule

Thank you for choosing TheraPeds to serve you. We are committed to providing you with the highest quality care. Please know that the services we provide will be billed to your health insurance provider unless you inform us that you will be paying for such services directly without submission to any third party payor and make arrangements with us for payment prior to the performance of any services. When changing health plans or insurers please provide us with updated coverage information. Failure to provide current insurance or health plan coverage information may result in your personal financial responsibility for the payment of all therapy costs to us.

TheraPeds is currently an in-network provider with the Ohio Department of Medicaid. If your current insurance provider is Medicaid, you Medicaid benefits may cover 100% of the payment for the evaluation and therapy. TheraPeds will bill the Ohio Department of Medicaid directly for both evaluations and therapy.

Families are responsible for informing TheraPeds of new insurance or health plan coverage information prior to each appointment. Failure to do so may result in an immediate pause on therapy sessions.

TheraPeds
Pediatric Therapy

General Acknowledgement and Agreement to Terms & Conditions of TheraPeds

- I hereby acknowledge and agree that I had read all of the forms and documents provided to me in connection with evaluation and treatment provided by FM Speech Therapy DBA TheraPeds ("TheraPeds") and/or its affiliates/employees.
- I hereby acknowledge and agree that I have viewed, read, and understand the HIPAA Notice of Practice Practices and have been informed of my rights with respect to the release and use of my child's personal health information as a patient's parent/guardian.
- I hereby acknowledge and agree that I have viewed, read, and understand the Payment Policy and agree to pay and be personally responsible for all charges incurred in connection with evaluation and therapy services performed on behalf of my child if not otherwise covered by my insurance or health plan.
- I understand the meaning and intent of the provided forms and information provided and agree to all content included.
- I have been given an opportunity to ask questions about the provided forms and information and all questions I've asked have been answered to my satisfaction by TheraPeds.
- **I acknowledge that all risks and benefits related to the care and treatments to be provided to my child have been discussed with me and I have had the opportunity to have all of my questions answered. I acknowledge that the practice of clinical therapy involves the exercise of medical and professional judgment and that there are no guarantees or warranties as to the results of any consultations, evaluations, treatments, or services that may be provided to or recommended for my child. I understand that I may withdraw this consent at any time by making a request in writing.**

TheraPeds

Authorization and Consent to Treat / Authorization to Release Information

- I authorize TheraPeds, the physicians and other licensed healthcare practitioners employed by or working on behalf of TheraPeds and any individual working under the direction of the licensed practitioners to render appropriate clinical evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained healthcare practitioner authorized to practice in the State of Ohio..
- I recognize, agree and understand that I have the right to refuse treatment by TheraPeds or terminate it services at any time by giving notice to TheraPeds. I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and TheraPeds' staff.
- I understand that state representatives, for the purpose of insurance certification or licensing and quality assurance, may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.
- In addition, TheraPeds may terminate services to my child by notifying me in writing and providing notice consistent with the requirements of Ohio law and practice standards.
- In consideration of the evaluations, treatments and/or services provided by TheraPeds, I irrevocably assign to TheraPeds all medical insurance benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan to issue payment directly to TheraPeds for care rendered to my child/dependent regardless of my insurance benefits, if any. I understand that I am responsible for all co-payments, amounts applied to the deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation.
- **I authorize TheraPeds and its affiliates to release medical information to and from other, non-TheraPeds affiliated members of my child's medical or educational team who are involved and the treatment and support of my child and who require access to my child's information to provide those services or support. I understand that medical information released to such third parties may be subject to further release and disclosure. I consent for TheraPeds, via all means of appropriate communication, to release and receive information that may include, but is not limited to, occupational therapy records, speech/language and hearing records, medical reports, academic information and program planning. I authorize TheraPeds and/or representatives to release all information acquired in the course of treatment to my insurance carrier. I authorize any holder of medical information to release to TheraPeds and its agents and/or representatives any information needed to determine my child's insurance benefits. This release will remain in effect until revoked by me in writing.**

By signing this form I agree, acknowledge, and understand the information in all of the referenced forms and I authorize and consent to the above.

Print Name of Child/Client	Date of Birth
✓ Signature of Parent/Guardian/Legal Representative	Mother Relationship to Client
Name of Parent/Guardian/Legal Representative	Date
Child's Pediatrician's Name (IMPORTANT)	✓ Insurance Carrier/HealthPlan

TheraPeds
Pediatric Therapy

Type text here

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO EARLY LEARNING CENTER/EDUCATIONAL PROGRAMS

Patient/Child's name: _____

Date of Birth: _____

This release authorizes FM Speech Therapy d/b/a TheraPeds ("TheraPeds") to share medical information related to the above named child's treatment and therapy with educators, staff, and other personnel at my child's early learning center or service location for purposes of incorporating such treatment and therapy information into his or her educational program and learning goals/outcomes.

By signing this release, I expressly authorize Therapeds and its employees and representatives to release and disclose my child's medical records and personal health information to the early learning center or service location named below for purposes incorporating such information into his or hers educational and learning program as necessary.

Name of Early Learning Center or Service Location:

Toledo Independent Childcare Center

I also understand that information used or disclosed pursuant to this release may be subject to re-disclosure by the early learning center or service location and may no longer be protected. I understand that I may revoke this authorization at any time by sending a written notice of revocation to both TheraPeds and the early learning center stating that I no longer wish to disclose information about my child. I understand that the revocation will have no effect on information already disclosed in reliance upon this release. Unless otherwise revoked, this release shall continue for as long as my child is a patient of TheraPeds. I understand that treatment, payment enrollment, or eligibility for benefits will not be conditioned on my failure to sign this release.

✓ _____ Date _____

Signature of Patient/Child's parent/guardian/legal representative

_____

Print Name and Relationship to Patient/Child

TheraPeds
Pediatric Therapy

Child History

1. Parent(s) / Guardians: _____
2. Address: _____
3. City, State, Zip: _____
4. Phone #1: _____ ☑ Cell ☐ Home ☐ Work ☐ Other
5. Email #1: _____

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom: _____

Is the child currently taking any medication? ☐ Yes ☐ No
Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Does the child have any known allergies? ☐ Yes ☑ No
Describe: _____

Child's Health:
1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)
2. The child was _____ lbs ____oz and _____ inches at birth
3. How was the child delivered? ☐Vaginally ☐Cesarean Section
4. Please describe any complications or concerns during labor or delivery:
_____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐PT _____
☐OT _____
☐SLP _____