TheraPLACE
Play, Live, And Communicate Effectively

Basic Information

Child's Name: _____ Date of Birth: ___/___/___ Gender: Female Male
Parent Name: _____ Occupation: _____
Home Address: _____
Phone Number: (___)____-_____ Cell: (___)____-_____
Parent Name: _____ Occupation: _____
Home Address: _____
Phone Number: (___)____-_____ Cell: (___)____-_____

Medical Information

Child's Referring Physician: _____ Phone: (___)____-_____
Name of Physician's Practice/Address_____
Reason for Referral: _____
Child's Primary Physician: _____ Phone: (___)____-_____
Physician Address: _____
Medical Diagnosis: _____
Mother's health during pregnancy (illnesses, accidents, medications): _____
Length of Pregnancy: Less than 30 weeks 30-36 weeks 37-40+ weeks
Delivery Complications: _____
Provide the approximate age if your child experienced any of the following:

Allergies _____	Ear Infections ____	High Fevers _____	Sinusitis ____
Asthma _____	Ear Tubes _____	Influenza _____	Tonsillitis ___
Croup _____	Encephalitis _____	Pneumonia _____	Other _____
Chicken Pox ___	Headaches _____	Seizures _____	

Allergy Information: _____
Child's current medications: _____
Has your child had any surgeries, major accidents, or hospitalizations? _____
_____

Developmental History

At which age did your child meet these milestones?

Roll Over _____	Skipped	Has not yet been achieved
Sit Independently _____	Skipped	Has not yet been achieved
Crawl on All Fours _____	Skipped	Has not yet been achieved
Cruise at Furniture _____	Skipped	Has not yet been achieved
Stand Independently _____	Skipped	Has not yet been achieved
Walk Independently _____	Skipped	Has not yet been achieved
Understand Spoken Language _____	Skipped	Has not yet been achieved
Speak First Word _____	Skipped	Has not yet been achieved
Use spoon independently _____	Skipped	Has not yet been achieved
Show Hand Preference _____	Skipped	Has not yet been achieved

At TheraPLACE, our therapists take pride in providing holistic, client-oriented services that lead to optimal client satisfaction. They strive to make gains in areas important to each individual family. The information collected below is vital to our providing the best services possible. Any comments are

appreciated, and will help us gain a greater understanding of your unique situation and how we can best support you at this time.

About Your Child

Name: _____ Date of Birth: ___/___/___

School/Daycare Attended: _____

Favorite Toys, Games, and Activities:

_____

_____

Favorite Food and Snacks: _____

_____

Community Activities:

_____

_____

Please list the names, ages, and any relevant comments about those living in the child's household.

_____

_____

What are your child's strengths? _____

_____

Which description(s) below sound like your child (check all that apply):

Mostly quiet	Very talkative	Overly active	Tires easily
Restless	Resistant to change	Often happy	Frequent tantrums
No fear	Lacks awareness	Nervous	Frequent unsafe behaviors
Easily frustrated	Unusual fears	Impulsive	Difficulty learning new things
Clumsy	Forceful	Notices everything	Short attention span

About Your Concerns

Please indicate your concerns below. Any and all comments are appreciated and will help us understand your wants, needs, and preferences for therapy. If you do not have concerns in a certain area, please indicate your satisfaction with that area, and move on to the next section.

Fine Motor Skills

Grasping Reaching Writing/Drawing Cutting Using both hands together

Other: _____

Comments: _____

Gross Motor Skills

Walking Running Jumping Throwing/Catching Coordination

Other: _____

Comments: _____

Communication Skills
How does your child communicate?
Gestures Single words Short phrases Sentences Sign Language
Other: _____
Comments: _____

Hearing
Hearing: No Concerns Concerns, not a priority Concerns, important to us
Hearing test completed: _____
Location of test: _____
Description: _____
Does your child repeat phrases from books or videos rather than make sentences: Yes No
Does your child "echo" phrases back at you: Yes No
Can your child answer simple questions: Yes No
Can your child follow simple directions: Yes No
Comments: _____

Activities of Daily Living Skills
Bathing/Showering: No Concerns Concerns, not a priority Concerns, priority
Description: _____

Bowel/Bladder Management: No Concerns Concerns, not a priority Concerns, priority
Description: _____

Dressing: No Concerns Concerns, not a priority Concerns, priority
Description: _____

Eating/Feeding: No Concerns Concerns, not a priority Concerns, priority
Good appetite Trouble with utensil use Limited variety Difficulty swallowing
Difficulty chewing Very messy Excessive drooling
Description: _____

Education: No Concerns Concerns, not a priority Concerns, priority
Poor handwriting Poor memory Left/Right confusion Letter recognition
Problems with math Procrastinates Forgets assignments Poor concentration
Does your child receive therapy services through school: Yes No
Description: _____
If so, what Individualized Education Plan (IEP) goals are most important to you: _____
_____

Hygiene and Grooming: No Concerns Concerns, not a priority Concerns, priority

Description: _____

Play/Leisure: No Concerns Concerns, not a priority Concerns, priority
Able to take turns Uses imaginative play
Description: _____

Sleep and Rest: No Concerns Concerns, not a priority Concerns, priority
Description: _____

Social Participation: No Concerns Concerns, not a priority Concerns, priority
Shy Aggressive Enjoys playing alone Enjoys playing with others
Plays near others, but not with them
Description: _____

Toilet Hygiene: No Concerns Concerns, not a priority Concerns, priority
Description: _____

Work: No Concerns Concerns, not a priority Concerns, priority
Description: _____

Do you have any concerns with skill level of sibling(s) related to:

Fine motor	Dressing/self-care	Eating/feeding
Gross motor	Attention	Communication

Other: _____

<u>Your Preferences</u>

How do you prefer to be contacted regarding services: Phone Email
Preferred e-mail address: _____
May be we leave voicemails regarding therapy services?
No Yes, Cell Yes, Home Yes, Work
Any information regarding specific rules you have for your child, how you deal with tantrum behaviors, etc.? _____
_____
_____
What else would you like us to know about your child?
_____
_____
_____

Person Completing This Form: _____

Relationship to Child: _____

Date: _____

EMERGENCY INFORMATION

Child's Full Name: _____ Birth Date: _____

Parent Name: _____

Phone: (____)_____Cell: _____

Parent Name: _____

Phone: (____)_____Cell: _____

Caregiver's Name:_____ Phone: (___)_____

Two persons to call if we cannot reach parents/caregiver in an emergency:

Name: _____ Relationship: _____ Phone: (___)_____

Name: _____ Relationship: _____ Phone: (___)_____

Conditions Which May Require Immediate or Emergency Care:
(i.e., diabetes, epilepsy, bee sting reactions, allergies, etc.)

1. _____ Treatment: _____

2. _____ Treatment: _____

If your child is taking medication on a regular basis, please indicate name of the medication and the purpose of the medication as well as any other pertinent information below:

_____

_____

If you child becomes ill or involved in an accident and you cannot be contacted, you authorize the following hospital or above-named physician to give the emergency medical treatment required:

Hospital: _____ Address: _____

I accept responsibility for any necessary expense incurred in the medical treatment of my child which is not covered by my insurance company.

Parent's Signature _____ Date _____

Authorization to Provide Services
Acknowledgement and Assumption of Risk

I, _____, acknowledge and agree to have my child, _____
(print name) (print child's name)
receive therapy and related services with any of the therapists at TheraPLACE Learning Center, LLC. I acknowledge that there is some risk inherent in the use of therapy equipment. I agree to indemnify and hold TheraPLACE Learning Center, LLC and its employees and/or independent contractors harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child, or our belongings.

I am aware that gross motor play is often encouraged during therapy. Swinging, running, climbing, and jumping assist with a variety of skills and performance components therapists may need to address. I consent to the use of gross motor play and agree to indemnify and hold harmless TheraPLACE and its employees and/or independent contractors from any injury sustained by my child resulting from this type of play.

I have read this Authorization to Provide Services, Acknowledgement and Assumption of Risk form and fully understand and accept the risks of the various services I am requesting.

_____ _____

Parent/Guardian Name (print, please) Parent/Guardian Signature

_____

Date

Permission to Release Information

I, _____ give my permission and consent to TheraPLACE Learning Center, LLC and
(print name)
it's employees (hereinafter, collectively, the "Company") to discuss and speak with school officials, teachers, psychiatrists, medical doctors, other therapists, insurance representatives, and other professionals (collectively, "Third Party Professionals") regarding _____
(print child's name)
as such may be needed in connection with the evaluation, treatment, and/or care of the said individual by the Company. In addition, the Company is authorized to receive any records, files, charts, and other documentation and information from such Third Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third Party Professional to the Company. Any person who is provided a copy of this document may rely on it as the undersigned's full and unconditional consent to the release of any and all information pertaining to the child.

The undersigned further authorizes the Company to release any and all information pertaining to the evaluation, treatment, and overall care of the said individual to any Third Party Professional that may in any way be involved in the evaluation, treatment, and/or care of the said individual. The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, as set forth above, the undersigned understands and acknowledges that he/she is agreeing to the release of such information notwithstanding the protections under HIPPA, provided, however, it is understood and agreed that the Company will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of evaluating, treating, and/or caring for the said individual. The undersigned, for his or herself and his or her successors and assigns, does hereby hold the Company harmless from any and all claims relating to the release of information as provided above, and does hereby waive and release any claim against the Company relating to the release of such information as provided above. I understand and agree that a photocopy or facsimile of this executed authorization is as valid as the original.

Please list therapists, teachers, physicians, etc. that you would like involved in the coordination of the individual's care.

Name: _____ Title: _____
Address: _____
Phone #: _____ Fax #: _____

Name: _____ Title: _____
Address: _____
Phone #: _____ Fax #: _____

Name: _____ Title: _____
Address: _____
Phone #: _____ Fax #: _____

Release of information to the following is *NOT* permitted.
Name: _____ Title: _____
Address: _____

Name:_____Title:_____
Address: _____

ٕ I do not give permission for TheraPLACE Learning Center, LLC to release any information regarding my child.

_____ ____ _____
___
Parent/Guardian Name (print, please) Parent/Guardian Signature

_____
Date:

Release for Educational, Teaching, and Volunteer Purposes

TheraPLACE is committed to promoting the growth of knowledge and giving back to the community that has helped us to grow. I, _____, authorize TheraPLACE employees and/or
(Print name)
independent contracts to allow my child, _____, to occasionally be observed
(print child's name)
during therapy sessions by fieldwork students, interns, and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only. I give consent for other professionals and students to participate in treatment sessions. I have the right to withdraw this consent on any day if I choose to do so.

_____ _____

Parent/Guardian Name (print, please) Parent/Guardian Signature

_____

Date

Clinic Etiquette

Thank you again for choosing to begin a relationship with TheraPLACE, where we strive to help others PLAY, LIVE, and COMMUNICATE EFFECTIVELY. In order to help ensure success for everyone involved, we ask that the following clinic etiquette policies be respected:

Session Standards

We ask that you arrive 5 minutes before your scheduled session time to ensure a smooth transition and meet your therapist at your scheduled session time. At times, our therapists have back to back appointments and will not be able to accommodate by allowing sessions to run late. We also ask that you be mindful of the time your session ends. Therapists generally have less than 5 minutes for discussion at the end of a session; if you need additional time, please set it up with your therapist in advance.

If you have children in diapers or pull ups, please bring the diaper bag to therapy, and be prepared to change your child if necessary.

Waiting Room

We understand that sometimes siblings may come along during therapy, and have provided some toys and games that we would LOVE for them to use while waiting. We only ask that these items are cleaned up and put away after use, and that accumulated trash is placed into the waiting room trash can. Please do not allow children to climb or jump. For safety purposes, please do not leave children unattended in the waiting room.

We ask that you not ask about other families at the clinic. Respectfully, we cannot answer those questions.

Accessing the Facility

To ensure HIPAA adherence, please check with a TheraPLACE employee before entering treatment areas. We understand that there are many fun and exciting supplies located inside of our facility. However, therapy supplies and gym equipment use must be reserved for the children and young adults receiving therapy services. This is to ensure therapists have access to the equipment they need and improve safe practices throughout the building. Interested in learning more about something you see? Ask your therapist and they will be happy to answer any questions.

Please accompany all children and anyone needing assistance or supervision to the restroom; this includes using the restroom for hand washing.

Attendance

We ask that you call us with the need to cancel sessions as soon as you discover that you will be unable to attend. Going on vacation in a month? It is not too soon to let us know!

We value your commitment to your child's attendance. However, for the protection of children and staff, we kindly request that you do not bring your child to therapy if he/she is experiencing the following symptoms: vomiting, diarrhea, fever, pink eye, and head lice; call with any other questions or concerns with symptoms your child may be experiencing. Please make sure that symptoms have been resolved for at least 24 hours prior to returning to therapy.

What you can expect from us:

1. Your sessions to start and end on time.
2. Information on targeted goals and happenings from the session.
3. Strategies and suggestions for follow through at home to increase carry over and help promote progress.
4. You can expect us to embody The TheraPLACE Mindset at every session.
6. You can expect to receive courteous and friendly assistance when scheduling appointments or asking with billing questions.

If you have any questions about the above information, please don't hesitate to ask us. We are here for you!

I have read and understood the above Clinic Etiquette and agree to abide by it.

_____ _____

Parent Signature Date

Confidentiality and Photo/Video Use Policy

At TheraPLACE, we are committed to maintaining client confidentiality. However, we are unable to meet with all of our clients in a private room at the end of each session. Therefore, we use the waiting room to provide you with information about your child's therapy session and home recommendations. We understand that you may prefer an alternative arrangement. If so, please let us know and we will accommodate you. If you prefer, you can schedule a meeting or phone consult with your child's therapist every 1-2 months in place of one of your child's sessions or in addition to his/her session.

Child's Full Name (print, please): _____

☐ I DO GIVE permission for my child's therapist at TheraPLACE to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session.

☐ I DO NOT GIVE permission for my child's therapist at TheraPLACE to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session. I will schedule a meeting or phone consult with my child's therapist every 1-2 months to discuss my child's therapy sessions. I understand that I will be billed for this meeting and that I may schedule this meeting in lieu of one of my child's therapy sessions.

☐ I DO GIVE permission for photograph/videotape of my child for the purposes of treatment, education, and documentation.

☐ I DO NOT GIVE permission for photograph/videotape of my child to be used for advertising, brochure, and/or webspace.

_____ _____

Parent/Guardian Name (print, please) Parent/Guardian Signature

_____

Date

CLIENT FINANCIAL RESPONSIBILITY HIGHLIGHT

We find that communication with our clients regarding our financial policy assists us in providing the best service to you. We have therefore taken the time to answer some of the most commonly asked questions.

HOW CAN I PAY?

Payment is due prior to each evaluation and treatment session. TheraPLACE accepts cash, checks, and debit and credit cards (including HSA and FSA). If you choose to pay by card, provide your card number, CVC code, expiration date, signature, and current email address on the following page. You will be provided with a receipt reflecting all payments. Place checks in "tuition" mailbox or leave card on file at main office.

FEES

The fee schedule for this year is outlined in our Policies and Procedures. We ask that you review that document very carefully before signing this form. Written reports for screenings and evaluations will not be provided until the entire balance is paid. Payments are due before services are provided. Services may be suspended if a payment is unable to be processed. We will contact you to make alternate arrangements prior to suspension of services. If it becomes necessary to send your account to an attorney for collection or to file suit to collect the account, you have agreed to pay the reasonable attorney's fees incurred. There is a $75 fee for returned checks, which must be paid before the provision of services can continue. Please note, services cannot begin until the Financial Agreement Form has been completed in its entirety.

OTHER QUESTIONS?

Just ask! We could not be here without you. So please, feel free to ask any questions you may have.

Financial Responsibility Signature Page

Thank you for reading the TheraPLACE Financial Policy. Please, ask any and all questions you have. We strive to maintain an open, understanding line of communication with everyone we serve.

_____ I understand that services are provided directly to my child and/or self and family, not to an insurance company. Thus, it is my responsibility to pay TheraPLACE directly and in full prior to receiving services. If I choose to do so, it is my responsibility to submit invoices to my insurance company for personal reimbursement.

_____ I also understand that if I do not give a cancellation notice I will be charged $25 per scheduled service. If I do not give a cancellation notice for a session during a Prime Time Spot (3:00pm-6:00pm), I will be charged $50 per scheduled service. If I do not give a 24 hour cancellation notice for a session during a holiday week, I will be charged in full per cancelled service. **Finally, if I miss 20% of my scheduled appointments, I may be asked to find another time slot that works better for me, discontinue services, or may potentially be placed back on a wait list.**

_____ I understand that if my unpaid balance reaches $200, services will be postponed until total balance is paid. If I do not pay off this balance within 2 weeks, I may be asked to discontinue services or potentially be placed back on the a list.

_____ I further understand that I am solely responsible for payment in full regardless of what my insurance reimburses, as TheraPLACE cannot render services on the assumption that charges will be paid for by the insurance company. I understand that the bill I am given, when attached to my insurance claim form, is usually accepted by the insurance companies as the provider's portion of the claim of the bill. I understand that a doctor's diagnosis and prescription for services is required for reimbursement for occupational therapy services. I understand that in all cases the services being provided by TheraPLACE may exceed the amount of time or number of sessions my insurance company will reimburse. I am solely responsible for keeping track of my number of authorized visits and my authorization period. I understand TherPLACE cannot track that for me.

Date: _____

Client Date of Birth: _____

Client Name (print): _____

Responsible Party (print): _____

Responsible Party Signature: _____

Relationship to Client: _____

Credit Card Authorization

Credit card charges for services will be processed by TheraPLACE Learning Center. If you plan to use a credit card to pay for your child's services, please complete this form in its entirety and return it to the main office so we can ensure your credit card is processed properly. Completion of this form authorizes TheraPLACE to process all service fees provided by this facility on the card listed below.

Name on card: _____

Authorizing Signature:_____

Billing address:

(Street Address)_____

(City, State) _____

(Zip Code) _____

Home phone number: _____

Credit card type: _____

Card number: _____

Expiration Date:_____

CVCCode: _____

Child's name: _____

Therapist's name: _____

I have read TheraPLACE's Policies and Procedures and fully understand the cost of the various services and billing process. I accept full financial responsibility for the services provided to my child.

_____ _____

___

Parent/Guardian Name (print, please) Parent/Guardian Signature

_____

Date

HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – CFR Parts 160 and 164)

1. I hereby authorize TheraPLACE Learning Center, LLC to use and/or disclose the protected health information ("PHI") of _____ (Patient) as described below.

A. Authorization for release of PHI cover the period of health care (check one)
   - □ from (date) _____ - to (date) _____OR
   - □ All past, present and future periods.

B. I hereby authorize the release of PHI as follows (check one):
   - □ Patient's complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   - □ Patient's complete health record *with the exception of the following information* (check as appropriate):
     - □ Mental health records
     - □ Communicable diseases (including HIV and AIDS)
     - □ Alcohol/drug abuse treatment
     - □ Other (please specify)
       _____

2. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding Patient's billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

3. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effect until five (5) years after cessation of treatment or _____, (date or event) at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand the patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient, Parent or Guardian: _____

Date: _____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 10/15/2013 and will remain in effect until TheraPLACE Learning Center, LLC replaces it. This Notice applies to you or your child, and you or your child's medical information, as appropriate.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to makes changes in our Notice effective for all health information that we maintain, including health information we created or received before making changes to this Notice. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of TheraPLACE's Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please use the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment, and health care operations. For example:

Treatment: We may use and disclose your health information to a physician, other health care provider proving treatment to you, or others involved in the coordination of care.

Payment: We may use and disclose your health information to obtain payment services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence of qualification of health care professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, and credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses and disclosers. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health supplies or information.

Marketing Health-related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic

violence or the possible victim of other crimes. We may not disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, text messages, e-mails, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other cost incurred by us as a result of complying with your request, to the extent permitted by applicable state or federal law. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, health care operations and certain other activities, for the last 6 years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your requests must specify the alternative means or location, and provided such requests do not create an undue burden on us, such communication will be made under the alternative means or to the location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Right to Express Complaints: You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, *please* contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made to access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and / or with the U.S. Department of Health and Human Services.

For more information about HIPAA or to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

In addition, we have a pre-recorded message with useful information about OCR:

toll-free: (800) 368-1019

TDD toll-free: (800)537-7697

http://www.hhs.gov/ocr/privacy/index.html

By signing below I acknowledge that I have read and received a copy of this Notice of Health Information and Disclosure.

_____ Date:_____

Signature of Patient, Parent or Guardian

General Acknowledgement of Forms

I, _____, do hereby acknowledge and agree that: (i) I have read all of
(Print Name)
the forms and documents provided to me in connection with the evaluation, treatment, and overall care of my child (or the child under my care) by TheraPLACE Learning Center, LLC and its employees or contractors; (ii) I understand the meaning and intent of such forms, and agree to the provisions contained therein; (iii) I have been given the opportunity to ask questions concerning any and all forms and all questions that I have asked have been answered to my satisfaction, and (iv) I have signed all of the forms of my own free will and without any undue influence or duress.

_____ _____

Parent/Guardian Name (print, please)

Parent/Guardian Signature

_____

Date