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, dosage, and side effects: _____
_____
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: _____

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? _____
_____
_____

EMERGENCY INFORMATION

Child's Full Name: _____ Birth Date: _____

Caregiver Name: _____ Phone: (____)_____ Cell: (___)_____

Caregiver Name: _____ Phone: (____)_____ Cell: (___)_____

Two people to call if we cannot reach caregivers in an emergency:

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

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

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

1. _____ Treatment: _____

2. _____ Treatment: _____

If your child is taking medication on a regular basis, please indicate name and purpose of the medication.

_____

_____

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.

_____ _____
Caregiver/Guardian Name Date

_____
Caregiver/Guardian Signature

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.

_____ _____

Caregiver/Guardian Name Date

_____

Caregiver/Guardian Signature

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.

_____ _____

Caregiver/Guardian Name Date

_____

Caregiver/Guardian Signature

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:

Upon Arrival

Please sign in at the front desk and pay co-pays, co-insurance, or out of pocket fees as before your session start time.

Session Standards

We ask that you arrive 5 minutes before your scheduled session time to ensure a smooth transition with plenty of time to sign in 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 schedule a consultation with your therapist in advance. The front desk staff can answer any questions regarding consultation cost.

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.

In the Waiting Room

Please feel free to enjoy any of the books and magazines in our waiting room. We understand that sometimes siblings may come along during therapy, and have provided some toys and games for them to use while waiting. We 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, head lice, and similar/related symptoms. TheraPLACE has a "no nit" policy regarding head lice. Children with head lice will require a note from a school nurse, pediatrician, or related healthcare professional stating that the child is nit and lice free. 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. Courteous and friendly assistance when scheduling appointments or asking 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.

_____ _____

Caregiver/Guardian Name Date

_____

Caregiver/Guardian Signature

Financial Responsibility Signature Page

Please, ask any and all questions you have. We strive to maintain an open, understanding line of communication with everyone we serve. **Please initial below to indicate you have read and understand each financial policy.**

_____ 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.** TheraPLACE accepts cash, checks, and debit and credit cards (including HSA and FSA). If you choose to pay by card, please provide your credit card information on the following page. You will be provided a receipt reflecting all payments.

_____ 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 agree to pay the reasonable attorney's fees incurred.

_____ I also understand that if I do not give a cancellation notice I will be charged $50. I understand that if a cancellation notice isn't given a day in advance I may be charged $50. These fees apply to all scheduled services including those provided to your child at school. **Finally, if I display a pattern of missed 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.** A doctor's note will be taken into consideration and kept on file.

_____ 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 on wait a list. Written reports for services will not be provided until the entire balance is paid.

_____ 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 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.

_____ 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.

_____ I authorize TheraPLACE Learning Center to charge the card on file for services rendered and additionally incurred fees.

_____ _____

Caregiver/Guardian Name Date

_____

Caregiver/Guardian Signature

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: _____

CVC Code: _____

Child'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.

_____ _____

Caregiver/Guardian Name Date

_____

Caregiver/Guardian Signature

HIPAA Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is effective as of 9/6/16 and replaces all previous notices. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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

_____ _____

Caregiver/Guardian Name Date

_____

Caregiver/Guardian Signature

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 Parent/Guardian: _____ Date: _____

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.

_____ _____

Caregiver/Guardian Name Date

_____

Caregiver/Guardian Signature