RightStart Therapy Services, Inc.
2295 Henry Clower Blvd., Suite 100
Snellville, GA 30078
Office #: 770-995-9600
Fax #: 678-922-7124
www.rightstarttherapykids.com

Patient Information/Consent Form

Patient Name: _____Gender: male female DOB: _____

Address: _____

Parent/Guardian 1 Name: _____ DOB: _____ SS#: _____

Cell #:_____ Home#:_____ Work #: _____

Employer: _____Email: _____

Parent/Guardian 2 Name: _____ DOB: _____ SS#:_____

Cell #: _____ _____ Home #: _____ Work #: _____

Employer: _____ Email: _____

Primary Care Physician

Name of Practice or Doctor: _____ Phone #: _____ Fax #: _____

Address: _____

Diagnosis or reason for referral: _____

Primary Insurance

Patient Name: _____ DOB: _____

Insured's Name: _____ relationship: _____ DOB: _____

Insurance Company: _____

Customer Service/Provider #: _____

Claims Address: _____

Member/Subscriber ID #: _____ Group /Account #: _____

Secondary Insurance

Patient Name: _____ DOB: _____

Insured's Name: _____ relationship: _____ DOB: _____

Insurance Company: _____ Customer Service #: _____

Claims Address: _____

Member ID #: _____ Group/Account #: _____

☐ I DO NOT HAVE INSURANCE OR I DO NOT WISH TO BILL MY INSURANCE FOR SERVICES RENDERED. I UNDERSTAND THAT RIGHTSTART THERAPY SERVICES, INC. REQUIRES THAT ALL PAYMENTS FOR SERVICES RENDERED BE PAID IN FULL AT THE TIME OF SERVICE. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY RIGHTSTART THERAPY SERVICES, INC. OF ANY CHANGES.

I hereby consent that all information provided on this form is true to the best of my knowledge.

_____ _____ _____

Parent/Guardian (print name) Parent/Guardian signature Date

It is important for authorization and billing purposes that you provide RightStart Therapy Services, Inc. with as much information about the services your child has received or is currently receiving. This does not mean that you will not receive services with RightStart Therapy Services, Inc.

Does your child receive Speech-Language, Occupational or Physical Therapy services within the Public School System?
_____

If yes, what county? _____ Frequency _____

To ensure accurate services are provided and that your child receives the best care, RightStart Therapy Services, Inc. **MUST** have a copy of your child's current IEP before providing services.

Most insurance companies require pre-certification or authorization to be in place prior to services being rendered. If there is another authorization in place with a different provider your insurance company will not approve services with RightStart Therapy Services, Inc. Therefore, you will be responsible for any charges denied by your insurance company for this reason.

Other than the school system; is your child receiving Speech-Language, Occupational or Physical Therapy services with another company? _____

If yes, please explain _____

_____ As a courtesy, RightStart Therapy Services, Inc. will verify your benefits with your insurance company. However, the verification of benefits is not a guarantee of payment. Claims payment is determined at the time services are rendered, eligibility at the time of service and exclusions or provisions on your plan. It is also recommended that you call your insurance company to verify your benefits.

_____ Please remember that each Medicaid program has different authorization requirements. It is very important that you notify our office of any changes. This will ensure that your child receives continuation of care and that we obtain authorizations as required by your policy.

_____ The insured/parent/guardian listed above is fully responsible for any balance due, non-covered services, and/or denied claims for any reason.

_____ I authorize RightStart Therapy Services, Inc. to release any medical records or other information necessary to process claims pertaining to my treatment.

_____ I authorize payment of medical benefits to RightStart Therapy Services, Inc. I also understand that it is my responsibility to inform this office of any insurance or address changes.

_____ I have been notified of all HIPAA regulations and I have received and read a copy of the Privacy Practice regulations implemented by RightStart Therapy Services, Inc.

_____ I understand that I am making a commitment based on the recommendations made by my clinician for my child. It is my responsibility to make sure that my child is at each scheduled appointment, report any changes in address or insurance coverage and to implement the home program provided by my child's clinician.

_____ My clinician will schedule a session with me to discuss my child(s) progress once a month; a 5 minute time slot during a regular scheduled therapy session.

_____ I understand that if I am late for a scheduled session that my clinician will only see my child for the remaining time and will not run into the next scheduled appointment.

I hereby consent that all information provided on this form is true to the best of my knowledge. I also understand that services will be provided as recommended by my physician and the Speech-Language Pathologist.

_____	_____	_____
Parent/Guardian (print name)	Parent/Guardian signature	Date

CANCELLATION POLICY:

Your child's progress in therapy is contingent upon consistency with your weekly scheduled appointments and the home program implemented by your therapist. RightStart Therapy Services, Inc. is committed to providing quality services to your family but it is the sole responsibility of the parent/guardian to reschedule any missed or cancelled appointments**. After 3 no show appointments and/or cancellations with less than a 24 hour notice will result in termination of services.** We do understand that sometimes circumstances present themselves and therefore will be considered on a case-by-case basis. Please call our office at 770-995-9600 or Jennifer Wright at 678-732-5320 should you need to cancel or reschedule your appointment.

There will be a $25 charge for all no call/no show appointments or calling less than 4 hours before your scheduled appointment. This will still count as one of your three cancellations.
An invoice for a no show appointment will be given at the next session; you will have two weeks to make the payment to your clinician, by cash or charge. After two weeks, therapy will be put on hold until the balance on your account is paid in full.

_____ _____
Signature Date

You agree **NOT** to leave the premises at any time for any reason while your child is in therapy. RightStart Therapy will **NOT** be held responsible for your child after their therapy session ends. If you wish to sit in your car or go outside you **MUST** be in the waiting room 5 minutes before your child's therapy session ends. This time allows you to speak with your child's therapist about the session and implement a home program. If you are not in the waiting room when your therapist brings your child out you will be charged a $25 late fee. If you are late your child's therapist will **NOT** have time to communicate with you about the therapy session or any information that may need to be shared. When your therapist brings your child to you after the session they are also there to pick up their next child. Therefore, if you are late, you are running into another child's therapy session. This $25 fee must be paid at your next scheduled appointment. **NO EXCEPTIONS**!!!

_____ _____
Signature Date

_____
Child's Name

RIGHTSTART THERAPY SERVICES, INC.
2295 HENRY CLOWER BLVD SUITE 100 SNELLVILLE, GA 30078 OFFICE: 770-995-9600 FAX: 678-922-7124

Authorization to use or disclose Protected Health Information

Patient Name: _____DOB: _____

Address: _____

Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practice without your authorization.

I hereby authorize _____ to use or disclose my Protected Health Information to the following person(s), entity(s), or business associates of this office:

_____

Name of business Address:

_____

Phone #: Fax #:

Patient Health Information authorized to be disclosed.

_____

_____

For the specific purpose of (describe in detail)

_____

_____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reason beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending a written note to this office and that revocation will not affect this offices previous release on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Protected Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of patient or patients authorized representative Date

If not the patient, your relationship to patient: _____

_____ _____

Authorized signature of facility Date

CONTACT INFORMATION

At times we may need to contact you for appointment reminders, cancellations or other concerns. Please complete **only** the items below that you authorize as a method of contact.
Note: Home address, one phone number and one email address are required.

Address: _____

Home Phone _____ OK to leave message: ☐Yes ☐No

Mother's Cell Phone _____ OK to text: ☐Yes ☐No

Mother's Work Phone _____ OK to leave message: ☐Yes ☐No

Mother's Email _____

Father's Cell Phone _____ OK to text: ☐Yes ☐No

Father's Work Phone _____ OK to leave message: ☐Yes ☐No

Father's Email _____

Please select the preferred contact methods (one only) for each item listed:

Appointment Reminders:	☐Home Phone	☐Mother's Cell (voice or text)
	☐Father's Cell (voice or text)	
Appointment Cancellations:	☐Home Phone	☐Mother's Cell (voice or text)
	☐Father's Cell (voice or text)	
Other Correspondence:	☐Home Phone	☐Mother's Cell (voice or text)
	☐Father's Cell (voice or text)	

Background Information

Patient Name: _____ Parent/Guardian: _____

DOB: _____ Gender: Male / Female Home Phone: _____

PCP (referring physician): _____

Other physicians and specialist who provide care to the patient: (list others on back of page)

Name _____ Specialty _____

Name _____ Specialty _____

Patient lives with (check one): ☐Birth Parents ☐Adoptive Parents ☐Foster Parents ☐One Parent

☐One Parent and Step-Parent ☐Other _____

Any language other than English spoken at home? ☐Yes ☐No If yes, what? _____

Does the patient speak the language? ☐Yes ☐No

Does the patient understand the language? ☐Yes ☐No

Who speaks the language? _____

Which language does the patient prefer to speak at home? _____

Please list the name, age and relation of those (other than parents) living in the patient's home.

NAME	AGE	RELATIONSHIP

Please list any of the patient's **relatives** having any of the conditions listed below: (e.g. Hearing Loss/Grandfather)

Mental/Intellectual Disability _____ Autism/PDD _____

Developmental Delay _____ Speech/Language Delay _____

Cleft Lip/Palate _____ Reading Difficulty _____

Other Birth Defect _____ Learning Disability _____

Hearing Loss _____ Attention Deficits _____

Other (specify) _____

What do you see as your child's most difficult problem? _____

_____

Does your child currently have a diagnosis? ☐Yes ☐No If yes, what is it? _____

Does your child attend a school or daycare? ☐Yes ☐No

If yes, where and current grade level? _____

Does your child have an Individualized Education Plan (IEP)? ☐Yes ☐No

If yes, what special services is your child receiving (speech, OT, PT, etc.)? _____

If yes, we will need a copy of the patient's most current IEP.

Birth History

Pregnancy: ☐Full Term ☐Premature (_____ weeks) Birth Weight: _____

Illnesses or accidents during pregnancy? _____

Use of alcohol, tobacco, or medications during pregnancy? _____

Delivery: ☐Vaginal ☐C-section ☐Breech ☐Feet First ☐Forceps/Suction Required

Other unusual conditions that may have affected pregnancy or birth? _____

_____

Did your child pass the infant hearing screening? ☐Yes ☐No

Medical History

Has your child had any of the following?

☐Adenoidectomy	☐Ear Tubes	☐Sleeping Difficulties
☐Allergies	☐Encephalitis	☐Surgery (specify below)
☐Breathing difficulties	☐Head Injury	☐Thumb/finger sucking
☐Breaths from mouth only	☐Hearing Problems	☐Tonsillectomy
☐Colds	☐ High Fevers	☐Tonsillitis
☐Ear Infections	☐Meningitis	☐Vision Problems
How often? _____	☐ Seizures	

_____

_____

Are immunizations current? ☐Yes ☐No

Is your child currently under a physician's care? ☐Yes ☐No

If yes, why? _____

Please list any medications your child takes regularly: _____

Does your child have any food or medical allergies? ☐Yes ☐No

If yes, explain: _____

Has your child or do they currently receive any therapy services (OT, PT, ABA, etc.)

Type of Therapy	Frequency of Visits	Dates of Services	Location	Treating Clinician

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ crawled	_____ sat up (no assistance)	_____ stood alone	_____ walked
_____ drink open cup	_____ drink with straw	_____ fed self (fingers)	_____ fed self (spoon/fork)
_____ dressed self	_____ toilet trained	_____ single words	_____ combined words

Is child left or right handed? _____

Does your child show unusual behavior (explain)? _____

Attention span for self-directed activities: _____ Adult-directed: _____

Does your child… (check all that apply)

☐Not eat enough variety ☐Only eat crunchy solids ☐Vomit during/after meals

☐Poor growth/weight gain ☐Aspiration (choking) ☐Only eats purees

☐Gagging ☐Frequent diarrhea ☐Only drink fluids

☐Avoids whole food groups ☐Frequent constipation ☐Transitioning from tube to oral feeding

☐Tooth brushing intolerance ☐Not eating enough volume ☐Food refusal

Favorite Foods: _____

Aversion Foods (if any): _____

Language Development

In which of the following areas does your child seem to have trouble? Check all that apply.

☐Hearing Sounds ☐Learning and using new words ☐Stuttering

☐Understanding what others say ☐Using sentences ☐Reading/writing

☐Saying speech sounds ☐Voice difficulties ☐other (please describe)

_____

How many words are in your child's expressive vocabulary? ☐0-5 ☐10-20 ☐25-50 ☐50+

Is your child difficult to understand (check all that applies)? ☐to you ☐to family members ☐to unfamiliar listeners

How long are your child's sentences? _____

Does your child have any difficulty understanding you (describe)? _____

Does your child have difficulty following directions (describe)? _____

Is your child aware/concerned/frustrated? _____

Sensory Processing

The following questions are designed to help gives us a more complete picture of your child. Check the choice which applies: Yes, No, Used to, or N/A (not old enough yet, or for other reasons, non-applicable).

Tactile (touch):

Does Child:	**YES**	**NO**	**Used to**	**N/A**
Like to be touched?				
Prefer to touch rather than be touched?				
Have a strong need to touch people or objects?				
Seem easily irritated or enraged when touched by others?				
Pinch, bite or otherwise hurt self or others?				
Dislike the feeling of certain clothing?				
Like to play in water, sand, mud, clay, etc?				
Mouth objects or clothes excessively?				

Vestibular (movement):

Does Child:	**YES**	**NO**	**Used to**	**N/A**
Like to swing?				
Get nauseous and vomit from other kinds of movement?				
Have fear in space (stairs, heights, etc.)?				
Lose balance easily?				

Visual:

Does Child:	YES	NO	Used to	N/A
Wear glasses?				
Avoid eye contact?				
Make reversals when writing, copying, reading?				
Have trouble with shapes, colors, size?				

Taste & Smell:

Does Child:	YES	NO	Used to	N/A
Chew on non-food items?				
Avoid certain textures?				

Auditory (Sound):

Does Child:	YES	NO	Used to	N/A
Hypersensitive to sounds?				
Have fear of unexpected noises?				
Have trouble understanding or following directions?				
Struggle to follow 2-3 step directions?				

Coordination:

Does Child:	YES	NO	Used to	N/A
Play with toys appropriately for age?				
Manipulate fasteners?				
Manipulate buttons?				
Manipulate zippers?				
Ties shoe laces?				
Put on clothes?				
Take off shoes and socks?				
Put on shoes and socks?				
Have trouble holding a pencil correctly?				
Trip or fall a lot?				
Grimace or use tongue in fine motor tasks?				

Behavior/Temperament:

Does/Is Child:	YES	NO	Used to	N/A
Highly active?				
Easy going, predictable?				
Rigid, set in ways?				
Adaptable, flexible?				
Able to play alone/entertain self?				

Become frustrated easily?				
Have short attention span?				
Become easily distracted?				
Struggle with making choices?				
Have self-stimulation behaviors?				
Act out?				

Social/Emotional History

What are your child's favorite toys/activities? _____

_____

_____

What typically calms/soothes your child? _____

_____

_____

What motivates your child most? _____

_____

What discipline methods work best? _____

_____

Does your child become easily frustrated with activities? ☐Yes ☐No If yes, please describe his/her behavior.

_____

_____

Does your child interact with other children, or primarily play alone? _____

_____

_____

What do you hope to gain from therapy at RightStart Therapy Services? _____

_____

_____

_____ _____

Parent/Guardian Signature Date

RightStart Therapy Services, Inc.
2295 HENRY CLOWER BLVD SUITE 100 SNELLVILLE, GA 30078 OFFICE: 770-995-9600 FAX: 678-922-7124

Consent

I give RightStart Therapy Services, Inc. my consent to use or disclose my protected health information or PHI to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review RightStart Therapy Services, Inc. Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that RightStart Therapy Services, Inc. has the right to change their Privacy Practices and that I may obtain any revised notices at RightStart Therapy Services, Inc.

I understand that I have the right for request a restriction of how my Protected Health Information is used. However, I also understand that RightStart Therapy Services, Inc. is not required to agree to the request. If RightStart Therapy Services, Inc. agrees to my requested restrictions they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

_____ _____

Signature of patient, parent or legal guardian Date

_____

If signed by someone other than patient, state relationship to the patient

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 CAREFULLY.

RightStart Therapy Services, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment-
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with RightStart Therapy Services, Inc."
"It is our policy to provide a substitute health care provider, authorized by RightStart Therapy Services, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment-
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to RightStart Therapy Services, Inc. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Emergencies-
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
If may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious an imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)
"No personal health information will be disclosed during a recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."
"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation is such event. It is not our policy to disclose any personal health information about your condition for the purpose of RightStart Therapy Services, Inc. sponsored fund-raising events."

Change of Ownership
In the event that RightStart Therapy Services, Inc. is sold or merged with another organization, your health information/records will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that RightStart Therapy Services, Inc. is not required to agree to the restriction that you have requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that RightStart Therapy Services, Inc. amend your protected health information. Please be advised, however, that RightStart Therapy Services, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by RightStart Therapy Services, Inc.
- You have a right to a paper copy of the Notice of Privacy Practices at any time upon request.

Change to this Notice of Privacy Practices
RightStart Therapy Services, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, RightStart Therapy Services, Inc. is required by law to comply with this Notice.

RightStart Therapy Services, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office.

Complaints
Complaints about your Privacy rights or how RightStart Therapy Services, Inc. has handled your health information should be directed to our office.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201