At **Spark Pediatric OT, PLLC**, we do our very best to gather all the necessary information to provide you and your child with the highest quality occupational therapy treatment. Please take some time to complete all the information requested prior to your appointment.

I have read and completed the following information:

☐ Notice of Patient Privacy Practices and Rights (HIPPA)

☐ Billing and Cancellation Policy

☐ Client Consent Form

☐ Intake and Birth History (3 pages)

☐ Credit Card Authorization Form

Billing & Cancellation Policy

Spark Pediatric OT, PLLC collects payment at the time of your visit or has permission to bill your credit card on file.

Please cancel your child's appointment as soon as you know you will be unable to attend the session. If the cancellation is reported less than 24 hours prior to the appointment time, a regular fee will be charged. In the case of a last-minute illness, we will attempt to reschedule the appointment.

Parent/Guardian Signature:_________________________ **Date:** _______________

Client Consent Form

_____ I give permission for **Spark Pediatric OT, PLLC/Robin Hellmann, MA, OTR/L** or **Elizabeth Silver, MA/OT** to provide occupational therapy services to my child.

_____ I give permission for **Spark Pediatric OT, PLLC/Robin Hellmann, MA, OTR/L** or **Elizabeth Silver, MA/OT** to periodically videotape and/or photograph during treatment sessions involving myself/my child, only to document progress and/or provide a visual for follow up at home.

_____ I will not hold **Spark Pediatric OT, PLLC/Robin Hellmann, MA, OTR/L** or **Elizabeth Silver, MA/OT** responsible for any injury that may occur on these premises or outside these premises regarding myself/my child during any given session.

_____ I give permission for **Spark Pediatric OT, PLLC/Robin Hellmann, MA, OTR/L** or **Elizabeth Silver, MA/OT** to consult verbally, via email or in written form with the following professionals:

Name: ______________________ **Name:** ______________________
Email: ______________________ **Email:** ______________________
Phone: ______________________ **Phone:** ______________________
Relationship: ______________________ **Relationship:** ______________________

Name: ______________________
Email: ______________________
Phone: ______________________
Relationship: ______________________

Parent/Guardian Signature: ________________________ **Date:** ____________________

Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain confidential.

Cardholder Name: ____

Billing Address: ____

____

____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: ______________________________

Expiration Date: ______________________________

Card Identification Number (last 3 digits located on the back of the credit card): ________

____I authorize Robin Hellmann, MA, OTR/L (Spark Pediatric OT) to charge all bills for services rendered to me to the credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. Copies of the bills and receipts for payment will be provided.

____I authorize Robin Hellmann, MA, OTR/L (Spark Pediatric OT) to bill my credit card for any services rendered if I do not pay for services within 1 day of receipt or if payment by check is voided or there is insufficient funds to cover the cost of services.

_____I authorize ______________ to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until the designated expiration date or until I cancel it in writing, whichever come s first, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Cardholder – Print Name, Sign and Date Below:

Signed: ______________________________

Dated: ______________________________

Name: ______________________________

Intake and Birth History

Today's date: ______________________

Child's name: ______________________ Date of birth: ___________

School: ______________________ Grade: ________________

Parent's names: ____

Siblings names and ages: ______________________

____

____

____

Pediatrician's name: ______________________ Phone number: _______________

Other medical professionals involved:
Name: ______________________ Phone number: _______________

Name: ______________________ Phone number: _______________

Name: ______________________ Phone number: _______________

Home address: ____

Home phone: ____

Cell phone: ____

Work phone: ____

Email address: ____

Child's interests: ____

Child's activities: ____

Medical diagnosis if any: ____

Who provided the diagnosis: ____

Parent's primary concerns: ____

____

____

Prenatal & Birth History

Describe pregnancy (any illnesses/injuries): ____

Were any drugs or medications taken during mother's pregnancy: ________________________

Delivery: Full term? ___ Premature? ___ If so, months and weight? ______________

Was it an unusual delivery? Breech ___ Caesarian ___ Other ______________________

Was the labor normal? Y ___ N ___ If no, was it prolonged, short, specify: _____________

____

Was medication given during delivery? ____

Was there a need for oxygen? _____

Were there any feeding difficulties (specify)? ____

Bottle fed? ___ Breast fed (if so, how long)? __________

Allergies: ____

Seizures: Y _____ N _____ If yes, please describe: _________________________

Injuries: ____

Hospitalizations: ____

Ear infections: Y _____ N _____ If yes, please describe: __________________

Medications: Y _____ N _____ If yes, please list: _________________________

Has your child ever received therapy services in the past (OT/PT/SLP/Psych)? And if so, what were the areas of focus? ____

____

____

Developmental Milestones

Record ages for the following milestones:

Sit: __________

Crawl: __________ Quality of crawl: ____

How long did child crawl for? ____________________

Cruise: __________

Walk: __________

Speak 1st word: __________

Toilet trained: Y ___ N ___ Bladder: ___ Bowel: ___

At what age did child:

Undress self: _____ Dressed self: ______

Manage snaps, zippers, buttons: _____

Preferred hand: R ___ L ___ Age establishes: ___ Not yet: ___

Tied shoes: _____

Any other relevant information: ____

____

____

____

____

Notice of Patient Privacy Practices and Rights

Name of Practice - Spark Pediatric OT, PLLC This notice describes how medical information about you may be disclosed and used, and how you can get access to this information. Please read carefully.

Your basic rights and our basic responsibilities under HIPAA. Patients of this practice have the right to obtain a copy of paper or electronic medical records, make corrections to the record, request confidential communication, request that we limit the information we share, get a list of entities with whom we have shared your information, get a copy of this notice, choose someone to act on your behalf, and file a complaint if you believe your privacy rights have been violated.

Get a copy (paper or electronic) of your records. We will provide a copy of your record, and can charge you 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 incomplete or incorrect.

Request preferred confidential communications. You can ask us to contact you by a preferred method (ie. Home/office/cell) or ask to send mail to a specified address.
Limit what we share or use. You can ask us not to share or use certain health information for our operations, treatment or payment, although we are allowed to refuse your request if it would affect your care. If you pay for a service out of pocket in full, you can ask us not to share that with your health insurer, and we will comply unless a law requires us to share that information.

Get a list of those with whom we have shared information. Upon request you are entitled to receive a list of the times we have shared your health information, who we shared it with, and why for up to six years prior to the date you asked. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures, such as any you requested. There is no charge for a yearly request of this list, but there is a reasonable cost-based fee if such list is requested more than once in a 12 month period.

Get a hard copy of this privacy notice. Upon request, you can receive a paper copy of this notice, if you have previously received this electronically.

Choose someone to act on your behalf. If someone is your legal guardian, or has medical power of attorney for you, that person can exercise your rights and make choices about your healthcare information. We will verify that any person has the authority to act on your behalf before taking any action.

File a complaint if you think your rights are violated. If you feel your rights have been violated, please contact us (info on page 1). You can file a complaint with the US Dept of

Health and Human Services Office of Civil Rights by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/, calling 877.696.6775 or writing to: US Dept of H and H Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

Your Basic choices and our basic responsibilities under HIPAA. For certain health care information, you can tell us your choices about what we share. You can tell us whether to share information with your family, close friends, others involved in your care. You can tell us whether to share information in a disaster relief situation. We will never share your information for the sale of the information or for marketing purposes unless we have express written permission. We can contact you in the case of fundraising, but you can tell us not to contact you again.

Our use and disclosures of your health information to treat you, run our practice or bill for your services. We may use and share your health information to treat you and share with others who are treating you. Ex – a child being treated by multiple therapists and disciplines. We can use and share your health information to run our practice, improve your care and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities. Ex- we give information to your insurer so they will pay for our services.

Other ways we may share or use your health information. We are required (upon request) to share your information in other ways that contribute to the public good, such as public health and research. These conditions are stringent and regulated by many laws before any information can be shared.

Help with safety and public health issues. We can share health information about you for certain situations such as preventing disease, helping with product recall, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, preventing or mitigating a serious threat to someone's health or safety.

Do research. We can use or share your information for health research.

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 information upon request when an individual dies.

Comply with the law, respond to any legal action. We will share information about you if state or federal law requires it, including any audits conducted by the Dept. of Health and Human Services. We can share information about you in response to a court or administrative order or in response to a subpoena.

Comply with worker's compensation, law enforcement, other gov't requests. Information about you can be shared for worker's comp claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Blue Button protocol. Any patients with medical care managed by the Blue Button protocol can learn more about access to their health information at http://www.hhs.gov/digitalstrategy/open-data/introducing-blue-button-plus.html

Summary of 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 will give you a hard copy of this notice and follow the duties and privacy practices described in this notice. We will not use or share your information other than as described here unless you tell us we can in writing that we can. You may also change your mind at any time and let us know in writing if you do. Add't info is available at: 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, on our website and in our office.

PATIENT INFORMATION CONSENT FORM

I have read and understand this practice's **Notice of Patient Information Practices**. I understand that the practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company. I also understand that the Company will consider requests for restrictions on a case-by-case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's **Notice of Patient Information Practices**. In doing so, I hereby release:

Spark Pediatric OT_ from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given, and no further confidential information will be released without the execution of an additional written authorization.

Patient and Parent/Guardian's Printed Name if Patient is under 18.

____

Printed Name

____

Signature