Pediatric Occupational Therapies

of Cobb and Bartow Counties

www.CathyShepherdOT.com

2896 Knob Hill Dr. SE
Atlanta, GA 30339
Phone: (770) 434-3999
Fax: (770) 783-6802

2655 Dallas Hwy., Suite 320
Marietta, GA 30064
Phone: (404) 314-7518
Fax: (770) 783-6802

Please print and complete the New Patient Registration Packet. In addition, the following is a checklist of information needed in order for us to evaluate and treat your child at Pediatric Therapies of Cobb and Bartow Counties:

☐ Doctor's prescription to read:
Occupational Therapy (OT) for 1 time(s) per week for 60 minutes for 6 months. The prescription must be signed and dated with the doctor's original signature and include the diagnosis and diagnosis code.

☐ Copy (front and back) of all your insurance card(s) – please enlarge when copying or write your policy ID #, group ID #, and insurance company phone number on the copy of your insurance cards (we can copy your insurance cards at our office)

☐ Completed and signed New Patient Registration Packet

☐ IFSP or IEP if applicable

☐ Previous reports/assessments/biomedical treatments/tests (if any)

Please fax the Registration Packet and Prescription to us at 770-783-6802 <u>prior</u> to your initial appointment.

In addition, we will also need the originals of the following information:
1. **Original doctor's prescription**
2. **New Patient Registration Packet forms with your original signature**

Please <u>bring</u> these original documents with you to your initial appointment <u>or mail to</u>:

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REGISTRATION INFORMATION

NAME: _____ DATE OF BIRTH: _____
PARENT/GUARDIAN:_____
ADDRESS: _____
_____ E-MAIL:_____
PHONE: _____ CELL: _____
PRIMARY DIAGNOSIS: _____ SECONDARY DIAGNOSIS: _____
PHYSICIAN: _____ PHONE: _____ FAX: _____
PHYSICIAN NPI#: _____

*Please fill in ALL of the information above.

INSURANCE INFORMATION:
PRIMARY: _____
POLICY HOLDER: _____ DOB: _____ SS#: _____
POLICY #: _____ GROUP #: _____
ADDRESS: _____
_____ CUSTOMER SERVICE #: _____
INSURED EMPLOYER: _____ PHONE: _____

SECONDARY:_____
POLICY HOLDER: _____ DOB: _____ SS#: _____
POLICY #: _____ GROUP #: _____
ADDRESS: _____
_____ CUSTOMER SERVICE #: _____
INSURED EMPLOYER: _____ PHONE: _____

MEDICAID INFORMATION:
MEDICAID #: _____
EXACT NAME ON MEDICAID CARD: _____
REGULAR MEDICAID ___ KATIE BECKET ___ PEACHCARE ___ (check one)

AUTHORIZATION AND CONSENT:
I authorize the release of all medical records necessary to ensure proper care and/or payment of benefits. I request that payment of benefits be made to Pediatric Occupational Therapies of Cobb and Bartow Counties. I agree to pay for all services not paid by insurance or any other third party payor.
Signature: _____ Date:_____

MEDICAL HISTORY

NAME: _____ DOB: _____

Pregnancy: ___ Full Term or ____ #weeks ___ vaginal delivery ___ C Section ____ Birth Wt.

Complications:

DuringPregnancy:_____

_____

During Birth:_____

_____

Current Medications:

_____

Hospitalizations:_____

Sickness: Thrush ____ Jaundice _____ Reflux _____ Ear Infections # _____

Sinus infections # _____ Respiratory # _____

Other Illnesses:

_____

_____

Allergies: Seasonal _____

Foods_____

Developmental Milestones:

At what age did your child: sit _____ crawl _____ walk ____ talk _____

Please describe concerns and issues that you want addressed in therapy:

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment and payment:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, physical therapists, occupational therapists, speech-language pathologists, dieticians, or other licensed health care professionals involved in your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law in cases of abuse or neglect.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about

you in response to a subpoena, discovery request, or other lawful process. Such disclosures will only be made after efforts to tell you about the request or to obtain an order protecting the information requested.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. You must submit your request in writing to the Privacy Officer of Pediatric Occupational Therapies of Cobb and Bartow Counties. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by a licensed health care professional other than the person who denied your request.
- **Right to Amend.** If you feel that information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as Pediatric Occupational Therapies of Cobb and Bartow Counties keeps the information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer of Pediatric Occupational Therapies of Cobb and Bartow Counties. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    1. Was not created by Pediatric Occupational Therapies of Cobb and Bartow Counties
    2. Is not part of the information kept by Pediatric Occupational Therapies of Cobb and Bartow Counties
    3. Is accurate and complete
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer of Pediatric Occupational Therapies of Cobb and Bartow Counties. Your request must state a time period which may be not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment and payment. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

  We are not required to agree to your request. If we do agree, we will comply with your request. To request restrictions, you must make your request in writing to the Privacy Officer of Pediatric Occupational Therapies of Cobb and Bartow Counties. In your request, you must tell us:
    1. What information you want to limit
    2. Whether you want to limit our use, disclosure, or both
    3. To whom you want the limits to apply
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to the Privacy Officer of Pediatric Occupational Therapies of Cobb and Bartow Counties. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask to receive a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you 5as well as any information we receive in the future. We will post a copy of the current notice in the main office of Pediatric Occupational Therapies of Cobb and Bartow

Counties. The notice will contain on the first page, in the top right hand corner, the effective date. You have a right to request the most recent notice. To obtain the most recent notice, please submit a request in writing to the Privacy Officer of Pediatric Occupational Therapies of Cobb and Bartow Counties.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of your legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For information regarding our Privacy Practices, please contact:

Cathy Shepherd, Privacy Officer
Pediatric Occupational Therapies of Cobb and Bartow Counties
2896 Knob Hill Drive, NW
Atlanta, Georgia 30339
(770) 434-3999

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(866) 627-7748 (toll free)

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, on behalf of _____
(Child's Name)
have received a copy of Pediatric Occupational Therapies of Cobb and Bartow Counties' Notice of Privacy Practices with an effective date of _____, 20_____.

NAME OF PATIENT: _____

ADDRESS OF PATIENT: _____

_____

SIGNATURE: _____ **DATE:** _____
Parent/Legal Guardian *Relationship*

SIGNATURE OF THERAPIST/WITNESS: _____ **DATE:** _____

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AUTHORIZATION AND CONSENT

Assignment and Release:

I request that payment of authorized benefits be made to Pediatric Occupational Therapies of Cobb and Bartow Counties on my behalf for any services provided to me. I agree to pay for all services not covered by insurance or any other third party payer, and to notify the provider of any changes in my Medicare or health insurance status. I authorize the release of all medical records necessary to ensure proper care, follow-up, and/or payment of benefits. I authorize a copy of this signature to be used in place of the original.

Authorization:

I have been informed of the reasons for the treatment/procedures, and I authorize Pediatric Occupational Therapies of Cobb and Bartow Counties to provide the necessary therapy services in the clinic/office setting and/or the natural environment (home, church, daycare, restaurants, retail stores). I authorize the disclosure of medical/therapy information to doctors, nurses, licensed healthcare professionals, daycare workers, baby-sitters, preschool teachers, and any other persons involved in my care. In addition, I authorize the use of sign-in sheets, answering machines and "message books" (notes to family members) in order to communicate with family members about therapy/procedures/activities and/or document attendance.

Signature: _____ Date: _____
Patient or person authorized to consent for patient