PATIENT/CONTACT INFORMATION

Patient Name: _____ Parent/guardian Name: _____
LAST FIRST MI

OT_____PT_____SPEECH_____ABA_____ Date of Birth: _____/_____/_____ ◯Male ◯Female

Address: _____
STREET CITY STATE ZIP

E-mail: _____Home: (_____) _____ - _____ Cell: (_____) _____-_____

Would you like Email appointment reminders? ◯Yes ◯ No

Emergency Contact: _____Phone: (_____) _____-_____ Relationship: _____

Primary Care Physician: _____Phone #: (_____) _____-_____

Referring Physician: _____ Phone #: (_____) _____-_____

CONSENT FOR THERAPY:

I hereby consent the staff of Up & Movin' Pediatric Therapy to provide therapy services to my child. The general benefits and contraindications of therapy treatment procedures have been explained to me to my full understanding. I am aware that the therapist does not diagnose illnesses or prescribe medications. I have informed the therapist of my child's physical conditions, medical conditions, and medications, and will update them of any changes.

Allergies: _____**No Known Drug/Food Allergies: _____**

Medical Conditions/Primary History: _____

Parent/Guardian Signature: _____ Date: _____

TURN OVER ➡

Up & Movin' Pediatric Therapy
6180 Brockton Ave. Ste. 102, Riverside, CA 92506
Phone: (951) 684-6500 Fax: (951) 684-0051

CLINIC POLICIES:

To provide the best care possible and to ensure patient safety and confidentiality, we request that **only children scheduled and undergoing treatment be allowed in the therapy area.** For your convenience and comfort, we have provided a waiting room located in the front of the clinic.

We also require **all Parents/Guardians/ Responsible parties to remain on the premises while the patient is undergoing therapy.** Up and Movin' Pediatric Therapy, will not be held liable or responsible for any children not in compliance with this policy. I have read and agree with the policy:

Parent/Guardian Signature: _____ **Date:** _____

NO SHOW/ CANCELLATION POLICY:

It is the parent/guardian's responsibility to provide 24-hour notice for any cancellations. It is our policy to **charge $50** if a client No Shows to his/her scheduled appointment. **Per policy, after 3 non-consecutive no-show appointments OR not attending sessions for 50 % of the month, your child may be removed from the schedule**. I have read and agree with the policy:

Parent/Guardian Signature: _____ **Date:** _____

VIDEOGRAPHY/PHOTOGRAPHY/LIVE STREAMING POLICY:

For the privacy of our patients, therapists and other employees we ask that there be **no photography, videotaping or live streaming in our clinic.** I have read and agree with the policy:

Parent/Guardian Signature: _____ **Date:** _____

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NOTICE TO PARENTS REGARDING THE PRIVACY PROVISIONS OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

PUBLIC LAW 104-191

The Health Insurance Portability and Accountability Act (Public Law 104-191) governs the disclosure of Individually Identifiable Health Information. These new regulations require that health care providers:

- Notify patients of the circumstances under which the health care provider may disclose Individually Identifiable Health Information
- Notify patients of their rights to access their individual health care information
- Notify patients of the steps they can take to correct any health care information that they believe to be inaccurate
- Notify patients of their right to receive an accounting of any instances in which their Individually Identifiable Health Information has been disclosed.

In addition, the regulations require that health care providers make a good faith attempt to obtain the signature of their patients (or the patient's parent or legal caregiver) acknowledging that they have been advised of the rights listed above.

Our policy regarding disclosures of Health Care Information:
The regulations permit the disclosure of Individually Identifiable Health Information for treatment, payment and health care operations without first obtaining the consent of the patient.
This means that we need to obtain your consent prior to disclosing Individually Identifiable Health Information to other health care professionals that may be participating in your child's treatment, to any funding agencies that are paying for your child's treatment or to clinic staff.

For example, we may routinely disclose Individually Identifiable Health Information to your child's physician, to any other therapist participating in the treatment of your child, to your Insurance carrier or to other funding agencies (such as school districts or regional centers) to the extent that the funding agency is being asked to pay for child's treatment.

To the extent that we need to disclose your child's Individually Identifiable Health Information for other than treatment, payment or clinic operation purposes, we will first seek your written consent each time we need to disclose information. If you choose to consent to the disclosure, you may later revoke your consent by notifying us in writing.

Your Right to Access Individually Identifiable Health Care Information
You have the right to review your child's file(s). In addition, you have the right to receive copies of any document in your child's file(s). We may, however, charge you for our copy and postage costs.

The steps you can take to correct Health Care information that you believe to be inaccurate
If you believe that any information contained in your child's file is incorrect, you can ask us to remove the information. If we do not agree to remove the information, you can ask that we insert in your child's file a statement indicating your disagreement with the information in the file.

Your right to receive an accounting of any instances in which your child's Health Care Information has been disclosed
On receipt of your written request, we will provide any accounting of any instances in which your child's information has been disclosed. This accounting will not include any instances in which your child's information has been disclosed for treatment, payment or operation purposes nor will it include any disclosures you have consented to.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

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