Up & Pediatric Therapy Movin' PC

INFORMATION DE PATIENTE/CONTACTO

Nombre de Patiente: _____ Padre or Guardián : _____

Apellido Nombre Segundo Nombre

Terapia Ocupacional ____ Terapia Física ____ Terapia de Lenguaje _____

Fecha de nacimiento: ____/____/_____ ○ Masculine ○ Femenino

Dirección: _____

Calle Ciudad Estado Codigo Postal

Correo Electrónico: _____ Casa: (____) ____-_____

Celular: (____) ____-_____

¿Desea recordatorios de citas por correo electrónico? ○Si ○ No

Contacto de Emergencia: _____

de Telefono: (_____) _____-_____ Relación : _____

Médico de Atención Primaria: _____ # de Telefono: (_____) _____-_____

Médico Referente: _____ # de Telefono : (_____) _____-_____

CONSENTIMIENTO PARA TERAPIA:

Por la presente estoy de acuerdo que el personal de Up & Movin' Pediatric Therapy pueden proporcionar servicios de terapia para mi hijo(a). Me han explicado a mi comprensión total los beneficios y contraindicaciones generales de Terapia Física. Soy consciente que los terapeutas no diagnostican enfermedades o prescriben medications. Les he informado a los terapuetas de las condiciones físicas, condiciones médicas y medicamentos, y los actualizará de cualquier cambio.

Alergias: _____

No se conocen alergias a medicamentos / alimentos: _____

Condición Médica /Historia Primaria: _____

Firma del Padre / Guardián: _____ Fetcha: _____

Voltear hacia atras

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

Up & Movin' Pediatric Therapy PC

Polices de clinica:

Para brindar la mejor atención possible y para garantizar la seguridad y confidencialidad del paciente, solicitamos que **solo niños programados y sometidos a tratamiento ser permitidos en el área de terapia**. Para su conveniencia y comodidad, nosotras hemos proporcionado una sala de espera, ubicado en el frente de la clínica.

Nosotros tambien requerimos **todo Padres / Guardianas / Partes responsables, permanecer en el local mientras los pacientes están en terapia.** Up and Movin' Pediatric Therapy, no se va hacer cargo o responsible para los niños que no cumpla con esta política. He leído y acepto la política.

Firma del Padre /Guardián:_____ Fetcha:_____

POLÍTICA DE NO PRESENTACIÓN / CANCELACIÓN

Es responsabilidad del Padre/Guardián proporcionar un aviso de 24 horas para cualquier cancelación. Es nuestra política **cobrar $ 50** si un cliente no se presenta a su cita programada. **Por política después de 3 citas consecutivas de no presentación O no asistir a sesiones durante el 50% del mes su hijo puede ser eliminado del horario** He leído y estoy de acuerdo con la política:

Firma del Padre /Guardián:_____ Fetcha: _____

POLÍTICA DE VIDEOGRAFIA /FOTOGRAFÍA/TRANSMISIÓN EN VIVO:

Por la privacidad de nuestros pacientes, Terapeutas y otros empleados Nosotras pedimos que **no haya fotografía, grabación de video o transmisión en vivo en nuestra clinica.** He leído y estoy de acuerdo con la política:

Firma del Padre /Guardián: _____ Fetcha: _____

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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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