Move, Learn, Play
Occupational Therapy

1072 Hwy 210, Suite B
Sneads Ferry, NC 2846
Phone: 910-290-2170

Fax: 910-319-0567

Email: admin@movelearnplaync.com

Patient Profile

Patients Name:_____ DOB:_____ Today's Date:_____

Parent/Guardian Name: _____Relationship with child:_____

Address:_____

City:_____ State:_____ Zip:_____ County:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Referred by: _____ Referral Date: _____

Reason for Referral: _____

Caregiver concerns:_____

Preferred Therapy location: home, clinic, school Available times:_____

Insurance Information

Private Insurance: Yes No Medicaid: Yes No
Insurance Name:_____ Medicaid Number:_____
Insurance Plan Number: _____
(Tricare provide military members social security number, name, and birthdate).
Insurance Group Number:_____
Family member covered:_____ Member DOB:_____
Insurance Plan phone number_____
Send Claim to address (info on back of card):_____
Medical Information:
Last Well Check Date: _____ Doctor Name: _____
Practice Name: _____ Phone number: _____
Address:_____ City, Zip, State:_____

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RELEASE OF MEDICAL INFORMATION

Patient's Name:_____
Patient Date of Birth:_____

I authorize Move, Learn, Play, Inc. to disclose and/or receive my/my child's health records and/or insurance information to/from the third party recipients designated below. This includes evaluations, goals, medical records, treatment notes, and any other relevant information. In the event that I want an agency, organization, or individual to receive information, but not to release (or vice versa), I will designate. Completion of this form is voluntary, and this authorization is in compliance with professional/client confidentiality and with the Health Insurance Portability and Accountability Act. You will need to list your/your child's physician/pediatrician, Infant Toddler Program, school system, equipment company, and any other medical specialist you/your child sees. Please use the back of this form if you need more space. Name of individual, organization or agency to release/receive information

Organization Name and Phone/Fax Number

_____ (Primary care physician/pediatrician)

_____ (CDSA/Infant Toddler Program)

_____ (School System)

_____ (DME & Prosthetics/Orthotics Co)

_____ (Other)

List any special instructions regarding this release of medical information:_____
_____
_____

_____ _____
Signature of Patient/Parent/Guardian Relationship to Patient Date

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INFECTION CONTROL
Communicable Disease Policy

POLICY:

It shall be the policy of MOVE, LEARN, PLAY, Inc. to abide by the following:

All patients, or parents/guardians of patients, shall telephone to cancel and reschedule appointments when the patient may have one or more symptoms of a contagious disease. This will aid in the protection of the health of the staff, other patients, and family members.

Symptoms:
- Fever >100 degrees F
- Vomiting / Nausea
- Open / Draining Lesion
- Lice
- Chicken Pox
- Measles
- Productive cough
- Impetigo
- Conjunctivitis / pink eye
- Strep Throat
- Diarrhea
- Any Other Contagious Disease Not Listed

I agree to abide by the above stated policy:

Parent / Guardian Signature _____ Date: _____

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Photo / Video Release

Move, Learn, Play, Inc. occasionally takes photos or short videos for treatment and assessment purposes. Move, Learn, Play, Inc. also has a website that is used for promotion and education.
Below is permission or a decline for Move, Learn, Play, Inc. to use these photos/videos for educational purposes and legal promotion of the clinic.

Check Only One Box Below and Fill out Only One Section Below.

Permission to Use Photograph

I grant to Move, Learn, Play, Inc., its representatives and employees the right to take photographs/video of my child. I agree that Move, Learn, Play, Inc. may use such photographs of my child with or without my name and for any lawful purpose, including for example such purposes as education, publicity, illustration, advertising, and Web content.

_____ I have read and understand the above and give permission for the above use:

Signature of Legal Guardian_____

Printed name _____

Child's Name _____ Date_____

_____ Check here if you DO NOT want your child's picture or video taken and used for Publicity but grant permission to use photos or videos for treatment or assessment purposes.

Signature of Legal Guardian_____

Printed name _____

Child's Name _____ Date_____

_____ Check here if you DO NOT want your child's picture or video for any purpose.

Signature of Legal Guardian_____

Printed name _____

Child's Name _____ Date_____

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Move, Learn, Play Inc. Admission Agreement

Patient's Name:_____ DOB:_____

Consent for Service:

I hereby authorize the staff of Move, Learn, Play, Inc. to administer therapy services as ordered by my physician and as are included in my plan of care. I acknowledge and agree that Move, Learn, Play, Inc. is not responsible for damage, theft or similar occurrences within my home during the provision of care by Move, Learn, Play, Inc. **By signing this document, I am requesting Move, Learn, Play, Inc. as the preferred provider for occupational therapy services.**

Agreement for Authorization and Payment of Services:

Medicare/Medicaid/Tricare Patients: I certify that the information given by me in applying for payment from my insurer is correct. I hereby authorize Move, Learn, Play, Inc. to provide my insurance carrier any information obtained during the course of evaluation/treatment necessary to authorize services and complete my insurance claims. I authorize my insurance provider to reimburse Move, Learn, Play, Inc. directly for all covered services rendered. I will be financially responsible for services/copays/supplies rendered that not paid by my insurance.

Private Insurance Patients: I certify that the information given by me in applying for payment from my insurer is correct. I hereby authorize Move, Learn, Play, Inc. to provide my insurance carrier any information obtained during the course of evaluation/treatment necessary to authorize services and complete my insurance claims. I authorize my insurance provider to reimburse Move, Learn, Play, Inc. directly for all covered services rendered. I will be financially responsible for services/copays/supplies rendered that are not paid by my insurance.

Self-Pay Patients: I understand that I will be billed for services and supplies rendered to me by Move, Learn, Play, Inc. I accept responsibility for payment for services/supplies rendered by Move, Learn, Play, Inc.

I further certify that the staff of Move, Learn, Play, Inc. has explained to my satisfaction my rights and responsibilities as a patient. I will have the opportunity to have the occupational therapy plan of care and goals explained to me and agree/disagree with them. **I understand my right to confidentiality and have received a copy of the "Notice of Privacy Practices."**

The undersigned party agrees to be responsible for and pay any obligations of the above patient's obligations owed to Move, Learn, Play, Inc. (Patient unable to sign).

_____ _____

Parent/Guardian's Signature Date

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Attendance Policy

At Move, Learn, Play, Inc. we require at least 75% attendance per month to maintain a regularly scheduled appointment. When appointments are missed, three people are affected: the patient, the therapist, and another patient that could have used the slot. Our practice is funded 100% by insurance/patient copays and private payments. Our therapists are paid based on the services provided, meaning if you do not come to an appointment, they do not get paid.

Due to our office scheduling and holding specific times weekly for each patient, you are reserving a specific time slot. We take careful attendance in order to monitor monthly attendance rates. This policy includes emergency, non-emergency, and vacation cancellations. If your attendance goes below our required 75% attendance policy, there is a chance you will be removed from the schedule, your reserved appointments will be filled, and you will be placed back onto our waiting list.

We appreciate that circumstances can impact attendance and we totally understand occasional schedule issues, however we have limited therapist availability and other patients who also need attention. Please make every effort to attend your appointments so that we can continue to provide you with the quality therapy.

Please review the following guidelines regarding attendance:

- Please arrive on time for therapy sessions.
- If you are tardy, you or your child's therapy session cannot always be extended to accommodate your late arrival.
- If you need to cancel an appointment, please call or text 24 hours in advance.
- Cancelling an appointment within the 24 hours of therapy slot is subject to a $25 fee. (Sickness and emergencies are excluded form this fee).
- If your call is not during our normal business hours, please leave a message or text us.

Thank you for your understanding and acceptance of our Attendance Policy and we look forward to seeing you!

Please sign at the below acknowledging that you have read our attendance policy and guidelines:

_____ _____

Parent/Guardian's Signature Date

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HIPAA Privacy Notice

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Move, Learn, Play, Inc. is dedicated to maintaining the privacy of individually identifiable health information as protected by law, including the Health Insurance Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. This information is referred to as protected health information or PHI. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our organization concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

This notice contains the following required information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our organization. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our organization has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our organization will post a copy of our current Privacy Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our organization may use your PHI to treat you. For example, we may ask you to have evaluations and we may use the results to help us develop an individual plan for services. Many of the people who work for our organization including, but not limited to, our therapists, educators, case managers, doctors, and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may also disclose your PHI to your primary care physician or other outside health care providers for purposes related to your treatment. Finally, we may disclose your PHI to family members or others who may assist in your care.

2. Payment. Our organization may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer, including Medicaid, to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to Medicaid and other payers or providers to coordinate and assist their billing efforts.

3. Health Care Operations. Our organization may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our organization. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our organization may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our organization may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our organization may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our organization may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a caregiver take an individual to the doctor's office for examination for seizures that occurred while at our organization. We may give the caregiver a copy of a case note for the physician documenting the seizure(s). In this example, the caregiver may have access to this individual's medical information.

8. Disclosures Required By Law. Our organization will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

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The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our organization may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult person served (including domestic violence) though we will only disclose this information if the person served agrees or we are required or authorized by law to disclose this information

2. Health Oversight Activities. Our organization may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our organization may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Persons. Our organization may release PHI to a medical examiner or coroner to identify cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our organization may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. Serious Threats to Health or Safety. Our organization may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. National Security. Our organization may disclose your PHI to federal officials for intelligence and national security activities authorized by law.

9. Workers' Compensation. Our organization may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

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You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Program Director or Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our organization will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members, guardians, and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Program Director or Privacy Officer. Your request must describe in a clear and concise fashion:

a. the information you wish restricted;

b. whether you are requesting to limit our organization's internal use, outside disclosure or both; and

c. to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Program Director or Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our organization may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to the Program Director or Privacy Officer. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the organization; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our persons served have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our organization has made of your PHI, e.g., for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine care in our organization is not required to be documented. For example, the therapist sharing information with the educator; the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our organization may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact any Program Director or the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, contact the any Program Director or the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, however, that we are required to retain records of your care.