Welcome to Tots To Teens Therapy Services, Inc.

We are so pleased you have chosen our company for your Speech Therapy, Occupational Therapy and Physical Therapy needs.
Please take a moment to complete the attached forms.
All applicable forms must be completed prior to all services**.**
Completed forms may be given to clinicians,
faxed to (719) 375-3116 Attn: Heather Otto,
or mailed to:
Tots To Teens Therapy Services, Inc.
12263 Charles Lacey Drive
Manassas, VA 20112

Forms:

Client Questionnaire - Personal Information/History - 2-6 pages (Required)
Consent for Release of Information - Page 7 – (Required for all Services)
Service Agreement Individual - Page 87 – (Required for all Services)
Billing Contract Individual - Page 9 – (Required for all Services)
Tricare Prime Billing Authorization – Page 10 – (Required ONLY for Tricare clients)
Credit Card Charge Authorization Form – Page 11 (Required for all Services)
Email/Text Authorization - Page 12 – (Recommended)
Notice of Privacy Practices - Pages 13 - 14 - Please read
Acknowledgement of Privacy Practices - Page 15 (Required for all Services)
Informed Consent – Teletherapy – Page 16
Important Information Page – Page 19 Please keep for your reference

Tots To Teens Therapy Services, Inc.

Client Questionnaire

Patient's Full Name_____
First Middle Last

Birthdate_____ Male_____/Female_____
Month Day Year

Address_____
Street City/State Zip Code

Telephone_____
Home Cell Work

E-mail Address_____

Referral Source_____

Reason for Referral_____

Primary Care Physician_____
*Please provide both the doctor's name and the name of the practice)

Primary Care Physician Phone Number _____

Primary Care Physician Address _____

_____

PARENT INFORMATION

Father's Name_____Birthdate_____

Address_____
Street City/State Zip Code

Father's Employer and Address_____

_____

Telephone_____
Home Cell Work

Mother's Name_____Birthdate_____

Address_____
Street City/State Zip Code

Mother's Employer and Address_____

Mother's Telephone_____
Home Cell Work

Parent's Marital Status_____

Siblings and Birthdates_____

_____

_____

Other persons living in the home_____

Second language spoken in home_____

Nature of problem_____

Date of Onset_____

Has your child previously been evaluated for this problem? _____

If yes, where? _____ Date of evaluation_____

FAMILY HISTORY

Have any of the following conditions affected members of your immediate family?

Cleft Lip/Palate_____ Neurologic Disease_____
Deafness_____ Stuttering_____
Delayed Speech_____ Other_____

Is your child adopted? _____ If so, at what age? _____

Is he/she aware of the adoption? _____

PREGNANCY AND BIRTH HISTORY

Did you have major health problems, injuries, or surgeries during your pregnancy? _____

If yes, please explain _____

_____

_____

Check any of the following that were applicable to you during your pregnancy:

German Measles _____ High Blood Pressure_____

RH/Blood Incompatibility _____ Virus Infections _____

Other_____

How long was your pregnancy? _____

How long was your labor? _____

Describe any labor complications _____

What was your baby's birth weight? _____

Were there any complications at the time of delivery? _____

If so, explain _____

EARLY DEVELOPMENTAL HISTORY

After birth, did the baby have any of the following conditions?

Convulsions _____ Feeding Problems _____

Heart Monitoring _____ Serious Infections_____

Severe Jaundice _____

At what age did your child sit alone? _____

At what age did your child walk alone? _____

At what age did your child feed self? _____

At what age did your child say his/her first word? _____

At what age did your child talk in sentences? _____

Does your child play with other children? _____

Does your child have severe or prolonged temper tantrums? _____

Does your child appear to have poor coordination? _____

Had your child shown any regression in Speech/Language Skills? If so, please provide details. _____

_____

_____

Has your child suffered from chronic ear infections? _____

Has your child ever had a psychological or neurological exam? _____

If so, where? _____ When? _____

Has your child ever been hospitalized? _____

If so, what was the reason? _____

Length of stay _____ Date _____

Is your child currently receiving any other forms of therapy or has he/she received other forms of therapy in the past? _____

If so, what type of therapy? _____

Dates _____

Is your child currently taking medications, supplements or vitamins? _____

If so, name of medication/supplement/vitamin _____

_____

Reason for medication, supplements or vitamins? _____

_____

EDUCATIONAL INFORMATION

Name of school child is presently attending _____

Describe general progress and behavior in school _____

_____

Is your child receiving any special services at school (i.e. speech therapy, occupational therapy, tutoring, etc.?) _____

Does your child have an IEP? If so, a copy must be provided prior to beginning therapy, and updated copies must be provided within seven (7) days of any new IEP meetings._____

Does your child appear to exhibit learning problems? _____

PARENT COMMENTS

Please describe any additional concerns/information you may have about your child's speech and language, eating, oral motor, motor skills or behavior at this time.

_____

_____

_____

_____

_____

_____

Tots To Teens Therapy Services, Inc.

CONSENT FOR RELEASE OF INFORMATION*

(*Pediatrician/PCM must be listed for all insurance clients)

Patient _____

Address _____
Street City/State Zip Code

Telephone _____

Date of Birth _____

I hereby give my consent for release of information concerning the evaluation and treatment of the above patient to the following people:

1. Name_____

   Address _____
   Street City/State Zip Code

   Telephone _____

2. Name _____

   Address _____
   Street City/State Zip Code

   Telephone _____

3. Name _____

   Address _____
   Street City/State Zip Code

   Telephone _____

I understand that Tots To Teens Therapy Services, Inc. preserves the confidentiality of client information. I further understand this release is valid for the period of time in which the patient is in active treatment with Tots To Teens Therapy Services, LLC or until revoked by the responsible party. A photocopy of this consent may be used as the original.

_____ _____
Signature of Responsible Party Date

Tots To Teens Therapy Services, Inc.

SERVICE AGREEMENT FOR INDIVIDUAL SESSIONS

Speech-Language Pathology, Occupational Therapy and Physical Therapy Services are provided for the patient with the understanding that payment for such services is the responsibility of the patient, parent, or guardian. **Payment is required at the time of service unless a Billing Contract has been completed. For all invoicing, payment is due upon receipt of invoice.** A late charge of $25.00 per month will be assessed on accounts not paid within the two-week grace period. Accounts more than 45 days in arrears may result in suspension of service. Accounts more than sixty days in arrears may be sent for collections and all applicable collection fees may be applied to the outstanding balance.

A 24-hour cancellation is required; otherwise, ALL failed appointments will be billed to the responsible party at our regular rate. Two failed appointments may result in cancellation of therapy services.

It is the responsibility of the patient, parent, or guardian to file for insurance reimbursement if applicable. Tots To Teen Therapy Services, Inc. is an in-network provider for Tricare. We are considered an out-of-network provider for all other insurance companies. Clients with no insurance, or any insurance other than Tricare are considered private pay, with the client responsible for full payment of all services. Tots To Teens Therapy does not accept or file insurance claims for any insurance company except Tricare. A detailed invoice with diagnosis codes will be provided.

All Tricare clients must:

1. Provide Tots To Teens a copy, front and back, of the sponsor's ID card prior to receiving any services.
2. Notify Tots To Teens immediate if there is any change in insurance coverage or eligibility.
3. Provide Tots To Teens a copy of the referral from the Primary Care Manager and/or an authorization from Tricare prior to receiving services.
4. Not obtain a referral or authorization for speech therapy, occupational therapy or physical therapy services from any other provider while receiving the same services from Tots To Teens Therapy Services. Tricare coverage only allows for these services to be covered by one provider.
5. For all clients over the age of three, provide Tots To Teens copies of all IEP's for the duration of the treatment period. If the client does not have an IEP, client must provide a letter from the client's school stating that no public services are being provided.
6. Failure to comply with the above requirements may result in the denial of insurance claims. In the event that a claim is denied, and client failed to comply with the above requirements, the client will be liable for full payment of all denied claims.
7. Denial/incorrect payment of claims by Tricare for six or more dates of service will result in suspension of all therapy services until payment in full is received.

I have read the above policy and agree to comply with said policy. I understand that payment is due at the end of each session unless a Billing Contract has been completed. I agree to pay all invoices upon receipt. I understand that it is my responsibility to file for insurance reimbursement, if applicable.

_____ _____

Signature of Responsible Party Date

Tots To Teens Therapy Services, Inc.

BILLING CONTRACT FOR INDIVIDUAL SESSIONS

To be completed for all billing arrangements:

Client Name:_____

Parent/Guardian:_____

Billing Address:_____

Street City/State Zip Code

E-mail Address:_____

Phone Number:_____

Home Cell Work

My preferred form of communication is:

_____Phone – Best time to call is_____

_____E-mail

Please send my invoice by:

_____U.S. Mail

_____E-mail (The invoice will be sent as a PDF attachment. Please complete an Email Authorization)

Fees for services rendered are the responsibility of the Client's Parent/Guardian. **All invoices are due upon receipt and should be paid promptly. A late charge of $25.00 per month will be assessed on accounts not paid within the two-week grace period. Accounts more than sixty days in arrears may be sent for collections and all applicable collection fees may be applied to the outstanding balance.**

*I have read and understand that payment is due upon receipt of the invoice. I understand that I will be assessed a late charge if payment is not made within two weeks of the invoice date. I understand that if I neglect payment for more than sixty days, my account may be sent for collections and all applicable fees may be added to the outstanding balance. *

_____ _____

Signature of Responsible Party Date

Tots To Teens Therapy Services, Inc.

TRICARE BILLING AUTHORZATION

Client Name: _____
(Last) (First) (Middle Initial)

Home Address: _____Apt # _____

_____
City, State, Zip Code

Home Phone #: _____-_____-_____ Other Phone #: _____-_____-_____

Client's Date of Birth: _____/ _____/ _____
Month/Day/ Year

INSURANCE INFORMATION:

Sponsor's Name: _____

Sponsor's Date of Birth: _____

Sponsor's Social Security # or Benefits #: _____

Client's Relationship to Sponsor: _____

REFERRAL INFORMATION:

Referring Physician: _____

Practice Name/Address: _____

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I understand that I am responsible for all services provided by Tots To Teens Therapy Services, Inc. I authorize Tots To Teens Therapy Services, Inc. to submit claims to Tricare Prime on my behalf. I authorize the release of any medical or other information necessary to process my claims.
.

Printed Name of Person Responsible for Account:

_____

Signature _____ Date_____

Tots To Teens Therapy Services, Inc.

Credit/Debit Card Charge Authorization Form

I authorize Tots To Teens Therapy Services, Inc. to charge the credit/debit card listed below, for services rendered and any related expenses. I further understand that it is my responsibility to notify Tots To Teens Therapy Services, Inc. of any changes to my credit/debit card information including address, zip code, updated expiration date, account number, and security (CVC) code. I understand I will be responsible for any bank chargeback fees in the event this information is not kept up to date.

Credit/Debit Card Information

Credit Card #_____

Name as it appears on Credit Card:_____

Expiration Date:_____ **Security (CVC) Code**_____

Billing Address:_____

Zip Code:_____

Please Choose One of the Following Options:

_____I hereby give consent for my credit card listed above to be charged the full amount due to Tots To Teens Therapy Services, Inc. on the last day of the month following services. I will be provided with an electronic invoice receipt after payment is charged.

_____I prefer to call monthly with my credit card number to pay my invoice. My credit card listed above will only be charged if payment is not received by the last day of the month following services. A $25.00 late fee will be added to the total amount due.

_____I prefer to pay my monthly invoice by check or cash. A $25 fee will be charged for all returned checks. My credit card listed above will only be charged if payment is not received by the last day of the month following services. A $25.00 late fee will be added to the total amount due.

Authorized Signature:_____

Date:_____ **Printed Name:**_____

Tots To Teens Therapy Services, Inc.

Email/Text Authorization

If you wish to communicate through the use of internet email or text, please complete the authorization below. In doing so, you authorize Tots To Teens Therapy Services, Inc. to send evaluations, therapy notes, general client correspondence, billing invoices and statements via the internet, and communicate with you regarding therapy via text message.

*I, _____, authorize Tots To Teens Therapy Services, Inc. to communicate with me through the use of internet email and text messaging services. I understand that I am responsible for any charges incurred as a result of the above.

_____

Print Name

_____

Signature

_____

Date

_____

Email Address

_____

Preferred Number for Text Messaging

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information. We must provide you with this Notice about our privacy practices, our legal responsibilities, and your rights concerning your health information. We will abide by the terms of this notice effective 1/1/2012, remaining in effect until replaced. We will accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling (719) 358-8756 and requesting a copy of our "Notice".

USES AND DISCLOSURES OF HEALTH INFROMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services for you. This includes health insurance companies as well as any business associate helping us obtain payment.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations to include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment, or healthcare operations, you may give us written authorization to use or disclose your health information to anyone for any purpose. Unless you give written permission, we cannot use or disclose your health information for any reason except those described in this Notice. Authorization may be resolved at anytime with written notification.

To Your Family and Friends: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care only if you agree that we may do so or in an emergency.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to any correctional institution or law enforcement official having lawful custody of protected health information to the extent necessary to avert serious threat to your health or safety or the safety of others.

Correspondence: We may use or disclose your health information to provide you with company correspondence, courtesy calls, and reminder calls through voicemail messages, emails, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information. You must make a request in writing to obtain access to your health information. Please send written requests to
Tots To Teens Therapy Services, Inc.
12263 Charles Lacey Dr., Manassas, VA 20112.

Disclosure: You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations, or correspondence. If you request this disclosure more than once in a 12-month period, we reserve the right to charge you a reasonable fee to offset the costs of additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use and disclosure of your health information. Although we are not required to agree to such requests, we will make every effort to acknowledge reasonable requests.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:

Tots To Teens Therapy Services, Inc.
Heather Otto
Office Manager
(719) 358-8756

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received or reviewed a copy of Tots To Teens Therapy Services Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement was unattainable because:

Individual refused to sign _____

Communication barriers prohibited obtaining acknowledgement _____

An emergency situation prevented us from obtaining acknowledgement_____

INFORMED CONSENT - TELEPRACTICE

Patient _____

Address _____
Street City/State Zip Code

Telephone _____

Date of Birth _____

I understand that participation in Tots To Teens Therapy Services, Inc. speech therapy and/or occupational therapy telepractice is voluntary and the same services may be available in the face to face setting. Tots To Teens Therapy Services, Inc. provides only natural environment therapy, therefore face to face availability is determined based on the physical location of required services and the availability of the SLP and/or OT and/or PT, and may not be available for all patients. The patient can stop the telepractice visit at any time and if available, request face to face services.

All clinicians providing telepractice services must follow telemedicine-specific regulatory, licensing, credentialing and privileging, malpractice and insurance laws and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the patient in receiving care, and shall ensure compliance as required by appropriate regulatory and accrediting agencies. All telepractice connections must meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

Telepractice platforms must utilize encryption using 128-bit Secure Sockets Layer (SSL). Video-chat applications (e.g. Skype, Facetime) are prohibited. The telepractice connections are designed so no Personal Health Information (PHI) in a telepractice session is stored or retained on any third party switches. Any recording of treatment session for store-forward use is done with screen capture programs on approved computers and stored in accordance with Tots To Teens Therapy Services, Inc. electronic Personal Health Information (ePHI) policy.

Each telepractice session is accessed by the patient using a unique password. Any stored or retained therapy materials are deleted at the time of patient discharge from treatment.

Online video/audio connections. All telepractice connections use TCP or HTTP/HTTPS. All traffic carried over HTTPS incorporate an encrypted 128 bit SSL connection.

Clinicians of telepractice services shall ensure that audio and video transmission used are secured using point-to-point encryption that meets recognized standards.

Clinicians of telepractice services shall not utilize videoconferencing software that allows multiple concurrent sessions to be opened by a single user. While only one session may be open at a time, a provider may include more than two sites/patients as participants in that session with the consent of all participants (e.g. group therapy).

All clinicians of telepractice services shall have an established alternate plan for communicating with the patient (or authorized representative) in the event of a technological breakdown/failure. This procedure should be developed at the outset of treatment. In order for the telepractice services to resume, all technological requirements of this policy must be restored. Telepractice cannot be performed by telephone services alone.

Any third party (e.g. family member, support staff, etc.) present during a telepractice session must be approved by both the clinician and patient (or legal representative).

During telepractice sessions:

- All online connections used during telepractice meet privacy standards. The only person present during treatment will be the authorized clinician, client and an eHelper The clinician is in a private room during treatment. The clinician's screen cannot be seen by unauthorized people.
- The patient should be aware of their location and who can see their computer. Do not locate yourself in a public location, or a location where someone else can see or hear the session.
- Services to be delivered:
    - Speech therapy, assessment or evaluation
    - Occupational therapy, assessment or evaluation
    - Physical therapy, assessment or evaluation
- Prior to telepractice beginning, the clinician will discuss any modifications to standardized assessment of treatment procedures that are used in telepractice that would be different than face to face.
- In order to begin telepractice, I will have the following:
    - Laptop or desktop computer with high speed internet access sufficient to transmit video and audio without lagging.
    - A camera and microphone connected to my laptop or desktop.
    - Create an account at https://zoom.us/meetings (free). I understand that I will need to download and install zoom_launcher.exe prior to the first telepractice session.

Tots To Teens Therapy Services, Inc.

I understand that in order to provide the maximum success during teletherapy sessions, an adult eHelper is required to be present for each visit. The adult eHelper will be responsible for the following:

- Coordinates telepractice appointments with the clinician.
- Accesses email to locate the link for telepractice sessions.
- Troubleshoots basic audio and video difficulties by listening to the directions of the telepractice provider and accessing those sites/tools on the computer.
- Assists the client in accessing web-based tools (highlighter, pointer, text tools, color pallet).
- Plays an active role in offering feedback to clinician about quality of video and audio, as well as materials being displayed.
- Establishes a distraction free environment for the client.
- Establishes proper seating for the client that allows access to the computer and offering appropriate lighting to aid in video transmission of the client.
- Attends solely to the needs of the client during telepractice sessions with no other job requirements.
- Demonstrates awareness of the client's strengths and needs and acquisition of a basic understanding of the client's communication and/or OT needs and knowledge of the therapy/IEP goals.
- Demonstrates understanding of therapeutic strategies and provides cueing and strategies at the right times to help the client become independent in responding to the telepractice clinician.
- Provides accurate feedback about the client's response to materials, restates the client's utterance if needed for clarification, and provides statements that will aid in completing tasks.

I have read all of the information provided regarding Tots To Teens Therapy Services, Inc. telepractice policy and consent to commencement of telepractice speech therapy and/or occupational therapy and/or physical therapy. I understand that all invoices will identify sessions as telepractice therapy and it is my responsibility to determine whether or not telepractice session are covered under my private insurance plan.

_____ _____

Signature of Responsible Party Date