# Happy Kids Therapies

Wanda Lowery, PT
37 W. Fairmont Avenue Suite 321
Phone 912-659-8099 Fax 912-257-7315

Patient Information

Date_____Name_____ DOB_____

Reason for Visit/Diagnosis_____

Home Address_____

City_____State_____ ZIP_____

Home Phone_____ Cell Phone_____Work Phone_____

Primary Physician_____ Phone Number_____

Referring Physician_____ Phone Number_____

Parent/Guardian Information

Mother/Guardian Name_____DOB _____

Address_____City_____State_____Zip_____

Email_____Cell Phone_____ Home Phone_____

Father/Guardian Name_____DOB _____

Address_____City_____State_____Zip_____

Email_____Cell Phone_____Home Phone_____

Insurance

Primary Insurance _____Policy #_____Group #_____

Insured Name_____Insured DOB_____ _____

Secondary Insurance _____Policy #_____Group #_____

Insured Name_____Insured DOB_____ _____

Additional Information

_____

_____

_____

_____

## Consent for Treatment and Release of Information

Permission is given for the necessary care/treatment of _____(child) by Wanda Lowery, PT as outlined by the state of Georgia. I understand the practice of therapeutic intervention is not an exact science and that treatment will involve physical participation of the patient which may involve risk of injury. I acknowledge that no guarantee has been made to me as the result of evaluation or treatment.

In connection with care and treatment of above named, I authorize Wanda Lowery, PT to release to, and receive from, any Doctor, Hospital, Clinic, or other Healthcare Provider, or Insurance Carrier any medical records or information relating to my child's health, including without limitation, any information relating to illness or disease cause, treatment, diagnoses, prognoses, laboratory and/or radiology test and/or procedures, and prescriptions.

I understand that permission for treatment or release of information may be revoked in writing at any time. I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. BY SIGNATURE, I AUTHORIZE TREATMENT AND RELEASE OF INFORMATION.

Parent/Guardian Signature_____Relationship_____Date_____

## Assignment of Benefits

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your medical/therapy benefits is between you and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. We are willing to complete insurance information forms and submit a claim on your behalf, however, we do not accept responsibility for the outcome of the transaction. Your acceptance of this policy and signature instructs your insurance company to make payment directly to our office. We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. We perform routine insurance billing procedures upon verification of coverage, however, our office does not guarantee that your insurance company will pay for treatment you receive from our practice. If your claim is denied, you will be responsible for paying the full amount at that time. Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation that your insurance company requests to sort out any confusion or questions that may arise. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. BY SIGNATURE, I AUTHORIZE MY INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO THE PROVIDER.

Parent/Guardian Signature_____Relationship_____Date_____

## Receipt of Notice of Privacy Practices

You have the right to review the privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy practices. I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. BY SIGNATURE, I VERIFY THAT I HAVE HAD THE OPPORTUNITY TO VIEW THE PRIVACY NOTICE BY REQUESTING A COPY OR HAVE READ THE COPY POSTED IN THE OFFICE.

Parent/Guardian Signature_____Relationship_____Date_____

Listed below are the names of the persons to whom our office may disclose the patient's private health information.

Name_____Relationship_____

Name_____Relationship_____

## Attendance Policy

Please contact our office by phone or text if you are unable to keep your scheduled appointment. If your child has two cancellations without prior notice or more than 50% cancellations with prior notice, your child will be discharged from therapy. I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. BY SIGNATURE, I AGREE TO THIS POLICY.

Parent/Guardian Signature_____Relationship_____Date_____

## Release for Appointment Reminders

I _____(Parent/Guardian) authorize Wanda Lowery, PT to send appointment reminders and requests for medical documentation that may include your child's first name only by phone message, text or Email.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. BY SIGNATURE, I AGREE TO THIS POLICY.

Parent/Guardian Signature_____Relationship_____Date_____

History

Child's Name_____Diagnosis_____

____Full Term ____Premature (____weeks) Complications with pregnancy or delivery_____

_____

Primary Physician _____

Specialists_____

Previous surgeries, accidents or hospitalizations and dates _____

_____

Current Medications_____

Allergies_____

Vision Tested ____yes ____no Date of last vision test and results_____

Hearing Tested ____yes ____no Date of last hearing test and results_____

Check all that apply to your child

____asthma ____breathing issues ____headaches ____dizziness ____tinnitus ____seizures ____sight problems ____allergies
____ear infections ____encephalitis ____tonsillitis ____sinusitis ____meningitis ____sleeping problems ____diabetes

Other_____

____orthotics/braces ____walker ____cane ____crutches ____stander ____trunk support/TLSO
____hearing aid(s) ____glasses ____KidKart/wheelchair ____adaptive seating ____gait trainer

Other_____

Developmental

Provide the approximate age (in months) at which the child began to do the following activities
roll_____sit_____crawl_____stand_____walk_____babble _____first words _____
drink from a cup_____feed self _____dress self_____

Educational Information

School_____

Grade_____Teacher_____IEP____yes ____no

Previous Therapy ____PT ____OT ____ST Location_____

Is child enrolled in Babies Can't Wait ____yes ____no IFSP ____yes ____no Service Coordinator_____

Special Skills, Strengths and Talents

List any hobbies, recreational, or specifics of your child's therapy needs.

_____

_____

Parent/Guardian Signature_____Relationship_____Date_____

Wanda Lowery, PT

# NOTICE OF PRIVACY POLICIES

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

**Introduction**

Wanda Lowery, PT, is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 05-01-2018, and applies to all protected health information as defined by federal regulations.

**Understanding Your Health Record/Information**

At each visit by Wanda Lowery, PT, a record of your visit is made. Typically, this record contains your symptoms, examination, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who con- tribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning
- A tool with which we can assess and continually work to improve the care rendered and the outcomes achieved

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

**Your Health Record/Information**

Although your health record is the physical property of Wanda Lowery, PT the following information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health records provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528, Obtain an accounting of disclosures of your health information as provided in 45 CFR 164,528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164,522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

**Our Responsibilities**

Wanda Lowery, PT is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to the legal duties and privacy practices with respect to information collected and maintain about you
- Abide by the terms of this notice
- Notify you of the inability to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

The right is reserved to change the practices and to make the new provisions effective for all protected health information maintained. Should the practices change, you will be mailed a revised notice to the address you've supplied, or if you agree, an email will be sent with the revised notice to you.

Your health information will not be disclosed without your authorization, except as described in this notice. Your health information will no longer be disclosed receipt of a written revocation of the authorization according to the procedures included in the authorization.

**For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the Wanda Lowery, PT at 912-659-8099 or at P.O. Box 15422, Savannah, GA 31416.

If you believe your privacy rights have been violated, you can file a complaint with Wanda Lowery, PT, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either Wanda Lowery, PT or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

**Examples of Disclosures for Treatment, Payment and Health Operations**

*We will use your health information for treatment.*

**For Example:** Information obtained by Wanda Lowery, PT will be recorded in your record and used to determine the course of treatment that should work best for you and how you are responding to treatment. We will use your health information for regular health operations.

For example: Wanda Lowery, PT may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in a effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Wanda Lowery, PT, using best judgment, may disclose to a family member, other relative, close personal friend, or any other person your identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: Information may be disclosed to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Communication: We may contact you to provide appointment reminders.

Public health: As required by law your health information may be provided to public health or legal authorities charge with preventing or controlling disease, injury, or disability.

Law enforcement: Health information may be disclosed for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct of have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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**Privacy Statement**

*You have the right to review the privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice. Signing below signifies that you have had the opportunity to view the privacy notice by requesting a copy or reading a copy located in the waiting room and you agree to the privacy policy of our office.*

**By signing below you acknowledge you have read, understand and agree to the Wanda Lowery, PT Financial Policy and our Notice of Privacy Practices**

Printed Patient Name_____Date_____

Signature of Patient/Insured/Guardian_____Date_____

Printed Name of Patient/Insured/Guardian_____Date_____

Signature of Office Representative_____Date_____

**Please list the names of the persons to whom we may disclose the patient's private health information and state how the individual is related to the patient**

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____