Building Great Kids Therapy
1738 Eagan Rd.
Madison, WI. 53704

Dear Patient Parent(s) or Legal Guardian(s):

Thank you for choosing Building Great Kids Therapy for your child's health care needs! If you are reading this letter, then your child has a referral for therapy and is currently completing their first evaluation. As a reminder, any and all Co-Pays are expected to be paid at the time of each visit.

Please read through the intake packet and fill out **ALL** the information. If you have questions, leave your answer(s) blank and we will assist you with them. In addition, you may be asked to fill out a questionnaire as part of your child's evaluation. Your child's evaluation should take about 60 minutes. Once that is complete, our friendly front office staff will assist you in scheduling any follow-up visits that are recommended. If your child qualifies for therapy, a Plan of Care and Evaluation Report will be provided to you at your child's next scheduled visit.

Our office staff will also assist you in setting up your patient portal account. The AthenaNet portal provides benefits such as appointment reminders, the opportunity to re-schedule appointments and the ability to send messages back and forth between you and your child's therapist. Directions for setting up your child's patient portal are in this packet as well as on our website. We encourage you to set this up in our office by using the AthenaNet email that will be sent to you.

We thank you again for choosing Building Great Kids Therapy and look forward to working with you and your child!

Sincerely,

Keith Ritsche M.S., OTR/L
Clinic Director/Occupational Therapist
Owner

1738 Eagan Rd., Madison, WI. 53704
(608)-286-1171
therapy@buildinggreatkids.com

Welcome to the Patient Portal!

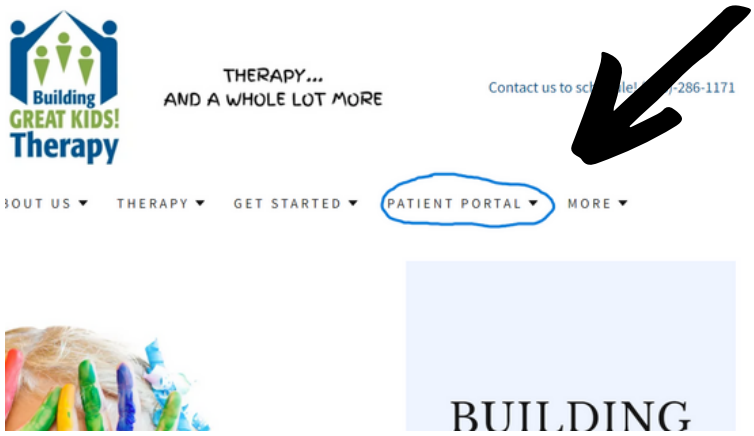
There are two options to access and register for the Patient Portal:

1. Registering in our office during your child's initial visit or,
2. Following the instructions on the email invitation that will be sent out to you. This option is preferred because AthenaNet will recognize your child's demographic information that has already been provided, who their provider is, and what department your child is registered in.

When you receive an email invitation from our clinic, open it, and click Register Now:

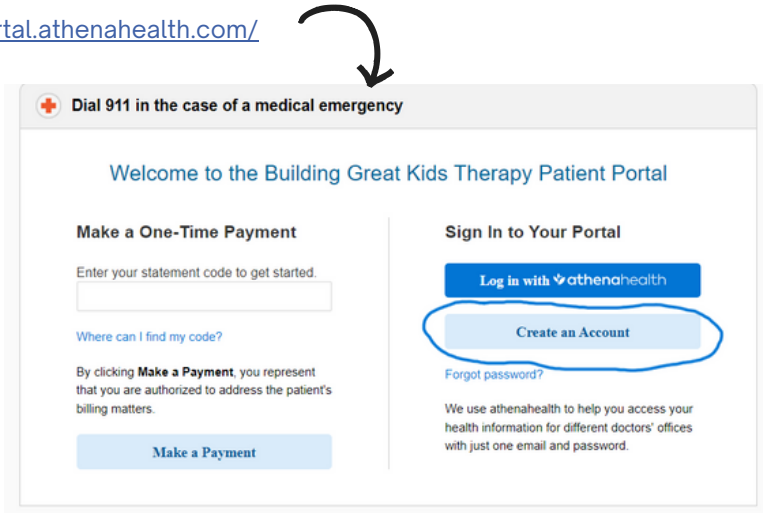
- The first factor of authentication is the email itself.
- The second factor is the call or text message that you receive to confirm your identity.
- Your identity is then confirmed when you respond to a message that the Patient Portal sends to the corresponding device that you used initially.

Once registered for the portal, you can access it from your email or by clicking on the portal link using our website https://buildinggreatkidstherapy.com.



Or, we also recommend adding the AthenaNet portal link URL to your favorites on whichever browser (s) you would be accessing it from.

https://26950.portal.athenahealth.com/



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WELCOME TO BUILDING GREAT KIDS THERAPY

Please take a few minutes to answer the following questions so we can better assist you with your child's health care needs. (Registration, pg. 1)

PATIENT INFORMATION

Name: _____ Social Security #: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Home phone #: _____ Consent to call: Yes ☐ No ☐

Cell phone#:_____ Consent to Text: Yes ☐ No ☐

Sex (circle one): Male Female Choose not to disclose E-mail Address: _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____Phone: _____

Visit Type: Occupational Therapy: ☐ Physical Therapy: ☐ Speech Therapy: ☐

PRIMARY INSURANCE

Insured name: _____

Person Responsible for Account/Relationship to Patient: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Copay Amount: _____ Co-Insurance: _____

Insured Employed by: _____ Business phone: _____

Insurance company: _____

Insurance company address: _____

Subscriber I.D. #: _____Group #:_____

ADDITIONAL INSURANCE (if applicable)

Insured name: _____

Person Responsible for Account/Relationship to Patient: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Copay Amount: _____

Insured Employed by: _____ Business phone: _____

Insurance company: _____

Insurance company address: _____

Subscriber I.D. #: _____Group #:_____

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WELCOME TO BUILDING GREAT KIDS THERAPY

Please take a few minutes to answer the following questions so we can better assist you with your child's health care needs. (Registration, pg. 2)

REASON FOR YOUR CHILD'S VISIT Please list your present health concerns, problems or diagnosis: _____

_____

_____

_____

_____

SCHOOL AND THERAPY SERVICES

School/program currently attending:_____ Present grade: _____

Does your child have an IEP from school? Yes ☐ No ☐ What does it cover? _____

_____

_____

Special services received in school: OT ☐ PT ☐ Speech Therapy ☐ Resource services ☐

Special education ☐ Behavior intervention ☐ Other special services _____

_____

Are there any accommodations being used with your child in their school environment? _____

_____

Does your child's teacher have concerns regarding your child's development? (Check all that apply):

- ☐ Motor skills
- ☐ Cognitive skills/learning abilities
- ☐ Sensory processing
- ☐ Self Regulation
- ☐ Difficulty following routines/directions
- ☐ Social abilities
- ☐ Self-help skills
- ☐ Organizational skills/staying on task
- ☐ Body awareness

Additional Comments: _____

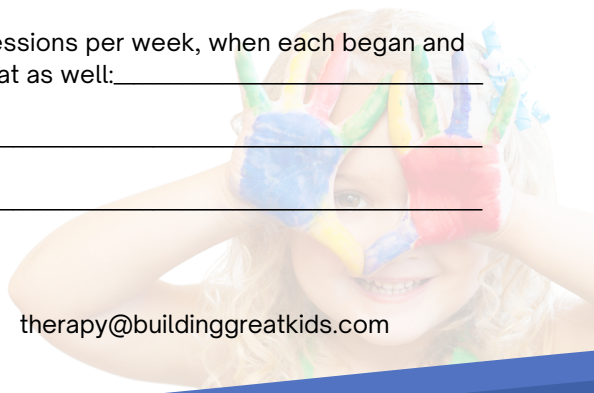
_____

Private Therapy Attended: OT ☐ PT ☐ Speech Therapy ☐ Birth-to-3 ☐ ABA Therapy ☐

Please provide detail regarding which therapies attended, how many sessions per week, when each began and were terminated. If there are some currently taking place, please list that as well:_____

_____

_____



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WELCOME TO BUILDING GREAT KIDS THERAPY

Please take a few minutes to answer the following questions so we can better assist you with your child's health care needs. (Registration, pg. 3)

RELEVANT MEDICAL INFORMATION

1.Physician(s) currently involved in your child's care: _____ Phone #:_____

_____ Phone #:_____

2.Current diagnoses/infections (please list): _____

_____

3.Recent hospitalizations: ____ No ____ Yes If yes, please describe: _____

_____

4.Recent surgery: ____ No ____ Yes If yes, please describe: _____

_____

5.Diagnostic tests: ____ Bone scan ____ MRI ____ CAT scan ____ Upper GI ____ Swallow study ____

X-rays Results: _____

6.Medications your child currently takes: _____

_____

7.Special equipment your child uses: ___Splint ___Braces ___Walker ___Crutches ___Wheelchair ___ Other___

Comments: _____

8.Previous psychological testing: ____ No ____ Yes Results of testing indicate (check all that apply):

☐ Learning Disability ☐ Developmental Delay ☐ Attention Deficit Disorder ☐ Hyperactivity

☐ Autism/Pervasive Developmental Disorder ☐ Behavioral Disturbance ☐ Depression

☐ Intellectual Disability

☐ Other, if yes, please explain: _____

9.Please check all that apply to your child (previous or current):

☐ Seizures ☐ Hearing difficulty ☐ Vision problem ☐ Wears Glasses ☐ Wears hearing aids

☐ G-Tube ☐ Ear infections ☐ Latex sensitivity ☐ Other _____

10. Allergies (Including food we should be aware of): _____

_____

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CLINIC EXPECTATIONS AGREEMENT

Building Great Kids Therapy appreciates the opportunity to provide services for your child. Please thoroughly read the following statement and sign/date at the bottom of the page.

“Patient siblings or children belonging to a parent/guardian of said patient receiving treatment are to be supervised ALWAYS. Non-patient individuals are NOT allowed in treatment rooms unless permission is granted by a clinic employee, therapist, etc. ALL individuals not participating in the therapy session must remain in the clinic waiting area/space. There may be times when family members can join the therapy session. For instance, the patient has earned free choice time at the end of the session and want’s to involve a family member or, a family member is asked at the therapist’s discretion to join the session to focus on patient social-emotional skills within family interaction. It is NOT permitted for non-patients to linger in the clinic hallway. This can cause a patient to become distracted and/or cause difficulties transitioning from one therapy room to another. It is permitted to use the clinic hallway to access the restroom. It is also permitted for a parent/guardian or family member to attend to an urgent matter pertaining to the patient (if one should arise) in a treatment space, room, etc.

Keep in mind that Building Great Kids Therapy asks this so that each patient’s therapy session is as individualized and beneficial as it can be. Please advise that we are not discouraging families from bringing siblings or other family members with them to the clinic. However, as practitioners, it is our obligation to provide each child with the best therapeutic environment so that we can help positively impact patient progress toward therapy objectives.

Children and/or family members are permitted to engage with clinic toys, books, drawing/coloring materials, magazines that are provided within the confines of the clinic waiting area/space. It is the family’s responsibility to make sure that the waiting area is clean and picked up as it was upon arrival.

If clinic toys or items are destroyed/broken by individuals not involved in the therapy session, each parent and/or caregiver will be expected to reimburse the clinic directly for the damages. We understand that accidents do happen and any reimbursement (s) for damages will be carefully reviewed and considered by the clinic director.

We appreciate you and your child working with us to ensure that your child is consistently provided the BEST care possible!”

I _____ (print name), agree to the statement listed above and understand that Building Great Kids Therapy holds the right to terminate a child’s therapy session at any time if the above expectations are not met.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name/Relationship to the Patient:

1738 Eagan Rd., Madison, WI. 53704

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FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

"***Thank you for choosing Building Great Kids Therapy for your child's health care needs. At Building Great Kids Therapy, "We empower children and their families with the tools to succeed at home, school and life!"***

Insurance Benefits:
It is not the responsibility of Building Great Kids Therapy to quote your insurance benefits. It is your responsibility to know and understand your benefits and address with your insurance company, any questions you may have pertaining to your benefits. Building Great Kids Therapy does contact your insurance company for a quote of benefits but this is not a guarantee of payment or coverage. We are not party to your contract or changes within that contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc. other than to supply factual information as necessary.

Filing Insurance:
As a courtesy, Building Great Kids Therapy will file a claim to your primary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. As stated earlier, your insurance policy is a contract between you and your insurance company. Building Great Kids Therapy will call on any unpaid claim(s) at least every 30 days. The family should call at least monthly to be sure claims are received and being processed. After 60 days, Building Great Kids Therapy will inform patients of unpaid claims. After 90 days without payment, the family will be responsible to begin paying on their account balance and private pay future appointments in order to remain on the treatment schedule. If a claim has been denied and is going through the appeals process, the family must begin paying on the balance and private paying new treatment sessions. As the client, you agree that if you default on any balance owed to Building Great Kids Therapy and it becomes necessary for Building Great Kids Therapy to engage the services of an attorney, collection agency or other lawful method of collection, you, the client, will pay the original balance owed and reimburse Building Great Kids Therapy for all costs incurred by the collection of said debt.

Copays, deductibles and coinsurance:
All copays are due at the time services are rendered. If your policy has a deducible, that has not been met, we collect a $50.00 payment at each appointment until the first Explanation of Benefits (EOB) is received from your insurance company. Any balance they have left for that date, you will have to pay at your next appointment. Any deducible and/or coinsurance amount is due upon receipt of the EOB in our office, at your appointment. For your convenience, we accept Visa, MasterCard and Discover in the office and over the phone. We can also keep your credit card on file in our secure database.

I give my consent to any appropriate and medically necessary procedures, medication, services or therapies that would be included in the treatment as required by the primary care physician or supervised staff for the above named person. I understand and acknowledge that I am financially responsible for all charges incurred during treatment at Building Great Kids Therapy, whether or not paid by insurance, rendered for the above named person.

The adult accompanying the patient is responsible for payment, for that day. We do not get involved in custody or other financial arrangements between parents. We will provide a receipt, if needed, so you can collect from another party.

Parent/Guardian Signature: _____ Date: _____

Print Name/Relationship to the Patient: _____

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REIMBURSEMENT POLICY

Patient Name: _____ Date of Birth: _____

The family is responsible to call their insurance company and be aware of their benefits. They are responsible to pay out of pocket fees at the time of service. Families need to keep track of the number of visits or when pre-certification is necessary. The number of visits and the payment of all claims is the responsibility of the family and not Building Great Kids Therapy.

Building Great Kids Therapy will call your insurance company, in addition to your call, to verify benefits. This is not proof of insurance payment! We also track the number of visits, but it is not our responsibility.

Building Great Kids Therapy, as a benefit to our clients, will submit claims to your insurance. This again is not our responsibility, but it being provided as a benefit to you.

Unpaid claims are called on Building Great Kids Therapy at least every 30 days. Families should call at least monthly to be sure claims are received and being processed.

After 60 days, Building Great Kids Therapy will inform patients of unpaid claims.

After 90 days without payment, the family will be responsible to begin paying on their account balance and private pay future appointments in order to remain on the treatment schedule.

If a claim has been denied and is going through the appeals process, the family must begin paying on the balance and private paying new treatment sessions.

Much of this can be avoided by knowing your policy and following up on your claims. The bills are ultimately your responsibility. Building Great Kids Therapy is only required, once treatment is provided, to give you the information to get reimbursed from your insurance company. Submitting the claims is not our responsibility, but a benefit to you.

Please help us to keep our costs down and to continue to provide the best quality care possible.
Thank you,

- Building Great Kids Therapy

Parent/Guardian Signature: _____ Date: _____

Print Name/Relationship to the Patient: _____

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therapy@buildinggreatkids.com

ASSIGNMENT AND RELEASE

Patient Name: _____ Date of Birth: _____

I hereby authorize payment directly to Building Great Kids Therapy for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize Building Great Kids Therapy to release the information required to secure the payment of benefits. I authorize the use of their licensed therapist signature's on all insurance submissions.

Parent/Guardian Signature: _____ Date: _____

Print Name/Relationship to the Patient: _____

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CANCELLATION POLICY

Patient Name: _____ Date of Birth: _____

Our greatest desire is to deliver our patient's the highest level of care available in order to maximize the benefits of therapy. Consistent attendance demonstrates patient commitment and leads to better potential for patient progress. With your help this can be accomplished.

Our payer sources are requesting daily progress notes as part of the review process for authorization of payment for therapy sessions. All absences are noted and require a reason for the cancellation to be noted. Excused absences include patient illness with doctor's note or note from the parent indicating the reason for cancellation. Extenuating circumstances of absences will be considered. Numerous absences or no shows may result in lack of child's progress in therapy.

Building Great Kids Therapy will enforce the attendance policy for clients who do not show or fail to cancel a therapy session with at least 24 hours prior notice, a $35 no show fee will be required. In order to avoid being discharged from the therapy program your child will need to maintain an 85% attendance rate. Notifications of vacations or family obligations are requested at least two weeks prior to the expected absence, to facilitate rescheduling appointment(s).

Same Day Cancellation = Patient has not given 24 hours or more notice.
No Show = Patient has not given 24 hour notice or has not called to cancel.

Rescheduling Appointments
Every attempt should be made to reschedule unattended therapy sessions. Rescheduled sessions may occur with the patient's therapist or other therapists. If your therapist is ill or on vacation, Building Great Kids Therapy will provide a substitute therapist to ensure continuation of services. We will make every effort to schedule the therapist at your regularly scheduled appointment time. If this cannot occur, Building Great Kids Therapy will provide an alternate appointment time.

Saturday Appointments
Saturday appointments may be made available (depending on clinic provider availability) in order to meet the needs of our patients who are not able to make therapy sessions during the week. If their becomes a growing need for Saturday appointments it would not be fair to hold open appointments for patients who do not show or frequently cancel. Therefore, Building Great Kids Therapy's policy for Saturday appointments is:

A patient will be removed from the Saturday schedule after one (1) "No Show".

Parent/Guardian Signature: _____ Date: _____

Print Name/Relationship to the Patient: _____

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

1. The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such complaint.
2. The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
3. The right to receive confidential communications of protected health information.
4. The right to inspect and copy protected health information.
5. The right to amend protected health information.
6. The right to receive an accounting of disclosures of protected health information.
7. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Parent/Guardian Signature: _____ Date: _____

Print Name/Relationship to the Patient: _____

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HIPAA COMPLIANCE

Patient Name: _____ Date of Birth: _____

I have received the Organized Health Care Arrangement (OHCA) Joint Notice of Privacy Practices and consent to the OHCAs use and disclosure of protected health information for the purposes as stated in the HIPAA JOINT NOTIFICATION OF PRIVACY PRACTICES. I understand the company members of the OHCA create and maintain health records and other information describing among other things, my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Joint Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing the consent. I understand that the OHCA reserves the right to change their Notice and Practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my protected health information for directory purposes. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carryout treatment, payment, or healthcare operations. The organization is not required to agree to the restrictions requested. By signing this form, I consent and authorize the OHCA to disclose treatment records, assessment reports, progress notes and any other information necessary to the patient's school, physician, and/or any other person or entity that would assist in patient's speech, occupational and/or physical therapy program, payment and health care operation. I have the right to revoke this consent, in writing, except where disclosures have already been made on my prior consent.

This consent is given freely with the understanding that:

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided by law.
- A photocopy or fax of this consent is as valid as this original.
- I have had the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment, payment, or health care operations, be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

Can we contact other family members or other individuals about the patient's general information & diagnosis? Yes ____ No ____ If yes, please list whom we may inform about the patient's general information and diagnosis (including treatment, payment and health care operations):

Name: _____ Phone: _____ Name: _____ Phone: _____

Can we contact family members or other individuals, about the patient's medical condition only in an emergency? Yes ____ No____ If yes, please list name & phone:

Name: _____ Phone: _____ Name: _____ Phone: _____

Can we contact you via telephone number? Yes ____ No____ If yes, please provide the number where we can call about the patient's appointments, test results or additional health information

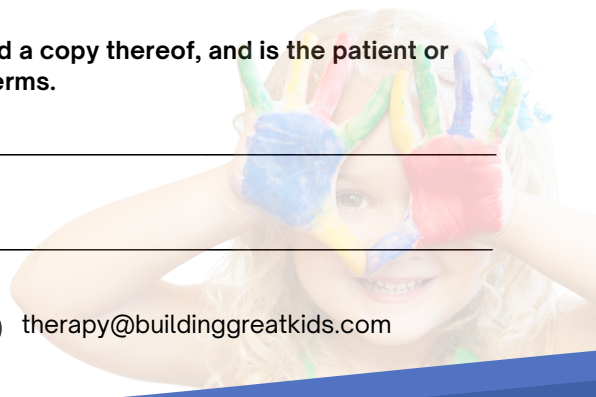
Home Phone: _____ Alternate Phone: _____

The undersigned certifies that they have read the foregoing, received a copy thereof, and is the patient or patient's legal representative to execute the above and accept its terms.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

Print Name/Relationship to the Patient: _____



1738 Eagan Rd., Madison, WI. 53704 (608)-286-1171 therapy@buildinggreatkids.com

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

I am completing this form to allow the use and sharing or protected health information about:

Patient Name: _____ Date of Birth: _____

I authorize disclosure of my child's protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below:

Please release information to:
Building Great Kids Therapy
1738 Eagan Rd.
Madison, WI. 53704
Phone: 608.286.1171
Fax: 833.699.2154

I want information released from:
Building Great Kids Therapy
1738 Eagan Rd.
Madison, WI. 53704
Phone: 608.286.1171
Fax: 833.699.2154

From: _____

_____

_____

_____

To: _____

_____

_____

_____

I authorize Building Great Kids Therapy to disclose the following information:

- ☐ **All the Below**
- ☐ **Evaluation Report**
- ☐ **Treatment Session Notes**
- ☐ **Billing Records**
- ☐ **Complete Copy of the Medical Record**
- ☐ **Other:** _____

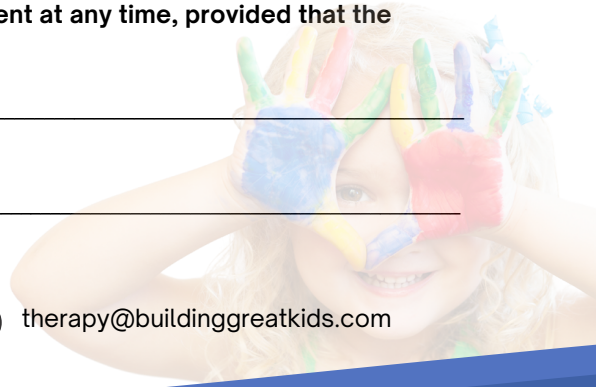
_____

_____

I understand and agree that this authorization will be valid and in effect for 12 months after completing this form. I understand that after that date, no more of this information can be used or released by Building Great Kids Therapy, unless I sign a new authorization form. I can revoke consent at any time, provided that the revocation is in writing.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Print Name/Relationship to the Patient: _____



Permission For Telehealth Visits

What is telehealth?

- Telehealth is a way to visit with your CCS Provider.
- You can talk to your provider from any place, including your home. You don't go to an office or clinic.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet using the link sent to you prior to the telehealth visit.
- Sometimes, you use video so you and your provider can see each other.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You consent to telehealth visits with your authorized CCS provider going forward.

Name: _____ Date: _____

Signature: _____

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