Building Blocks Pediatrics, LLC
Therapy at its Best!
ATLANTA | BUCKHEAD | MARIETTA

Office: 770.321.6705
Fax: 404-551-3891

Welcome to Building Blocks Pediatrics
Providing Comprehensive Therapy for Your Child

The following documents must be completed, signed and returned to our office before your child's first schedule appointment.

1. **(REQUIRED) New Patient Intake Paperwork** which includes the **SIGNED** Patient Service Agreement, **SIGNED** Patient Authorizations and Permissions, **SIGNED** Patient Attendance Policy, **SIGNED** Acknowledgement receipt of the Notice of Privacy Practices, and **SIGNED** Automatic Payment Authorization form.
2. **(REQUIRED) PRESCRIPTION for THERAPY SERVICES**: please have your child's healthcare provider fax and/or email a prescription for services including a diagnosis code for PT, OT, and/or ST stating, "Evaluate and Treat". (This is extremely important so we can courtesy bill your insurance provider.)
3. **(REQIURED) UPLOAD** a copy of your child's insurance card and a copy of the parent/guardian Photo ID.
4. **(If Applicable) UPLOAD** any current OT/PT/ST evaluations (within the past 12 months), pertinent medical information which will assist us in your child's therapy treatment and current IEP and/or IFSP (within the past 12 months).

We have Two Convenient Locations
East Cobb (Marietta) and Buckhead

East Cobb /Surrounding Areas: 1230 Johnson Ferry Place Ste G-10 Marietta, GA 30068

FROM DOWNTOWN: Go North on 75 and exit Delk Rd -go east (right) on Delk Rd- it will turn into Terrell Mill and then Lower Roswell (stay straight). Drive East for approximately 10-13 minutes. Make a Left (north) onto Johnson Ferry Rd. Make a Right onto Johnson Ferry Place (at light). Make 2nd Right into parking lot (at mailbox). We are in building 2 G (Suite is G-10).

Buckhead/Surrounding Areas: 267 West Wieuca Rd NE Ste 101 Atlanta, GA 30342

FROM DOWNTOWN: Go North on I75 and I85 toward GA 400 North/Greenville. Merge onto GA 400 North toward Buckhead/Cumming. Take GA 141-Conn Lenox Rd Exit toward Buckhead. Turn slight left to take the GA-141 W ramp toward Piedmont Rd. Merge onto Lenox Road NE/GA-141 Conn West. Turn slight right onto Piedmont Rd NE/GA237. Turn Right onto Roswell Rd NE/US-19/GA-9. Turn right onto West Wieuca Rd- Our suite is 101.

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Notice of Privacy Practices
Building Blocks Pediatrics, LLC

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 LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14th, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change to our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment, and health care operations. For Example:

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

Payment: We may use and disclose your health information to obtain payment of services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence of qualifications of health care professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, and credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care operations you give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you as described in the patient rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

People Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, or your

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location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapability or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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 what 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 not 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 authorized federal officials' health required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, postcards, emails, or letters.)

Patient Rights

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities for the last 6 years, but not before April 14th, 2003. You must make your request in writing. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information, by alternative means or to alternate locations. (You must make your request in writing). Your requests must specify the alternative means or location and provide satisfactory explanations that will be handled under the alternative means location of your request.

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Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing and direct your complaint to the Privacy Leader.

Right to Obtain a Paper Copy of this Privacy Summary Notice as well as the Full Privacy Notice.

Questions and Complaints:

If you want more information about our privacy practices, or have questions, or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or disagree with a decision we made access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US Department of Health and Human Services upon request.

We support your right to privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and/or with the US Department of Health and Human Services

For more information about HIPAA or to File a complaint:
The US Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington DC 20201
877-696-6775 (toll free)

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Patient Information

Today's Date: ________________________

Child's Full Name: ____ DOB: ______________ Gender ☐ M ☐ F

Home Address: ____ City: __________________________

State: __________ Zip Code: ________________

Home Phone Number: ________________________ Email: ____

Person filling out this form: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other

Mother's Full Name: ____ DOB: ______________

Mother's Cell Phone: ____________________________________

Mother's Employer: ______________________________________ Work Phone: _____________________

Father's Full Name: ____ DOB: ___________________

Father's Cell Phone: ____

Father's Employer: ______________________________________ Work Phone: ____________________

Marital Status of Parents: _______________________________________

Person with whom child resides: __________________________________

Primary Physician: ________________________________ Physician Phone Number: ___________________

Referring Physician (if different): _______________________ Physician Phone: _______________________

Diagnosis (if known):

____

Primary Insurance

Primary Insurance Company: ____

Member ID/Policy #: ___________________________________ Group Number: ______________________

Client Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

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Insured Full Name: ____

Insured Phone Number: _____________________________ Insured Date of Birth: _______________

Insured Sex: ☐ Male ☐ Female

Insured Street Address: _____________________________ Insured City: _________________

Insured State: ___________________ Insured Zip Code: ______________________

Secondary Insurance

Secondary Insurance Company: ____

Member ID/Policy #: ________________________________ Group Number: ____________________

Client Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Full Name: ____

Insured Phone Number: _____________________________ Insured Date of Birth: _______________

Insured Sex: ☐ Male ☐ Female

Insured Street Address: _____________________________ Insured City: _________________

Insured State: ___________________ Insured Zip Code: ______________________

Please list all the people living in your household:

NAME	AGE	RELATIONSHIP TO CHILD	SPEECH/HEARING OR MEDICAL PROBLEM?
Primary Language spoken in the home:			

School/Preschool: _______________________________________ Grade: _______________

Does your child have an IEP or IFSP? ☐ Yes ☐ No

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Does your child currently receive therapy services through school? ☐ Yes ☐ No

PLEASE EXPLAIN THE CONCERNS YOU HAVE ABOUT YOUR CHILD?
(Include when this was first noticed and/or what may have caused it, etc.

____
____
____
____
____

Has anyone else expressed concerns (i.e., family members, pediatrician, teachers, etc.)?
____
____

Is your child currently receiving outpatient therapy services? ☐ Yes ☐ No
If YES, which discipline (OT/PT/ST), name of facility and for how long?
____

Has your child received therapy services in the past? ☐ Yes ☐ No
If YES, what discipline (OT/PT/ST), name of facility and for how long?
____

Is your child adopted? ☐ Yes ☐ No
Adoption Background: ____
____
____

<u>Medical History</u>
How many weeks was your child born? _____________ Birth Weight? _____________

Did your child go home as expected? ☐ Yes ☐ No

Were there any complications during the pregnancy, delivery or immediately after? ☐ Yes ☐ No
If YES, please explain:
____
____

List any unusual problems during first few weeks of life:
____
____

Has your child had his/her hearing checked in the past year? ☐ Yes ☐ No Date: _________________

Has your child had his/her vision checked in the past year? ☐ Yes ☐ No Date: _________________

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	Yes	No
History of ear problems?		
History of allergies, tonsillitis, or asthma?		
Are there any diagnosed medical, physical, or emotional problems?		
Have there been any serious illnesses, injuries, or hospitalizations?		
Does your child have any allergies?		
Does your child take medication?		

If YES to any of the above questions, please explain and give dates:

____

____

____

DEVELOPMENTAL MILESTONES	AGE	COMMENTS
Sat up independently		
Crawled		
Walked Alone		
Spoke First Word		
Put several words together		
Dressed Self		
Finger fed self		
Ate with utensils		
Toilet trained		

Does your child have any of the following?

Socializing Problems ☐ Yes ☐ No

Feeding Problems ☐ Yes ☐ No

Sleeping Problems ☐ Yes ☐ No

If YES for any of the above, please explain:

____

____

____

Does your child get along with other children? ☐ Yes ☐ No Age of playmates ________________________
If NO, please explain:

____

____

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How does your child usually let you know their wants/needs? ____

Does your child communicate well with you/others? ☐ Yes ☐ No
If NO, please explain:
____
____

Does your child do the following:

Answer when you talk to him/her? ☐ Yes ☐ No
Talk about what they are doing? ☐ Yes ☐ No
Ask for help? ☐ Yes ☐ No

What are your child's interests? (Favorite toys/activities/songs)
____
____

Is your child enrolled in any community activities (music class, play groups, Mother's Morning Out Program?
____

Please list your goals for therapy:
____
____
____
____

Printed name of Parent/Legal Guardian: ____

Signature of Parent/Legal Guardian: ____

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Patient Service Agreement

I, ____ (parent/legal guardian), knowing that ___________________________________ (child's name) has a diagnosis requiring Occupational, Speech, or Physical Therapy treatment (OT, ST, PT) voluntarily consent to such care for the aforementioned child by Building Blocks Pediatrics, LLC as may be beneficial in the professional judgment of the child's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of OT, ST, or PT on my child. **Parent Initials** __________

I hereby authorize Building Blocks Pediatrics, LLC Billing department to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to Building Blocks Pediatrics, LLC. I understand that the patient or patient's family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage if insurance refuses to pay provider a portion of the fees or in full. I agree to pay all fees within 15 days after the bill has been sent and understand that if any fees not paid within 15 days will result in a 10% or greater late fee. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay all additional associated banking, legal, and/or collection fees. I understand that I am ultimately responsible for payment of all services received. I understand that I am advised to fully know and understand my insurance benefits prior to my child receiving therapy services. I understand that all insurance plans are different, and it is impossible for Building Blocks Pediatrics, LLC to know the specifics of my plan or if my plan will reimburse for services received. Regardless of insurance verification or anticipated insurance coverage, I agree to pay all fees accrued for services received. **Parent Initials** _________

I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills and performance components the therapist may need to address. I consent to use of gross motor play and exempt my child, therapist(s) and employee(s) and owner(s) of Building Blocks Pediatrics, LLC, from any injury resulting from this type of play. **Parent Initials** ________

I am aware that Building Blocks Pediatrics, LLC is a teaching and learning facility. Students and other health care professionals come to this facility to learn and observe treatments being performed or led by my child's OT, PT, and/or ST. I give consent for other professionals and students to participate in treatment sessions. I have the right to withdraw this consent on any day if I choose to do so. **Parent Initials** _________

Parent/Legal Guardian Printed Name: ____

Parent/Caregiver/Guardian Signature: ____

Date________________________

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Patient Authorizations and Permissions

Authorization for the Release of Medical Records

I, ____ as legal parent/guardian of _____________________________ (name of minor patient), hereby authorize Building Blocks Pediatrics, LLC to obtain and release all of this patient's medical records, case records, case histories, and/or personal and regular files for the purpose of financial reimbursement, continuity of care and case management from and to all current and former providers of medical services (to include: primary care physician, psychologists, etc.). I understand and agree that a photocopy or facsimile of this executed authorization is as valid as the original.

Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization, and my consent has been made voluntary.

Printed name of Parent/Legal Guardian: ____

Signature of Parent/Caregiver/Guardian: ____

Date ___________________

Acknowledgement of Receipt of the Notice of Privacy Practices

I hereby acknowledge that I have read/received/downloaded a copy of Building Blocks Pediatrics, LLC Notice of Privacy Practices with an effective date of 4/14/03, as it relates to my child.

Name of Child: _______________________________________

Name of Parent/Legal Guardian: ____

Signature of Parent/ Legal Guardian: _______________________________________

Date: __________________

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Permission for Family to Leave Site During Treatment

I understand that while my child is receiving therapy, I may leave the premises. I agree to leave a working cell phone number where I can be reached during my absence. I agree that I will not travel more than ten miles from the facility and will return at least five minutes prior to the end of my child's therapy session. I give consent and permission to Building Blocks Pediatrics for any additional treatment or transportation that may be needed in the event my child is injured or needs medical attention. I understand that failure to comply with the requirements listed above will result in an immediate revocation of this ability. I also understand that the ability to continue to leave the premises while my child is in therapy is at the discretion of Building Blocks Pediatrics and/or the therapist and may be revoked at any time.

I hereby release Building Blocks Pediatrics, LLC, and any agents as well as any assignees, from all claims for damages related to my leaving the premises during my child's therapy session.

Child's Name: ______________________________________ Cell Phone Number: _______________________

Parent/Legal Guardian Printed Name: ____

Parent/Legal Guardian Signature: ____

Secondary Emergency contact Name/Phone Number: ____

Photograph/Video

Photographs/videos are sometimes used for educational and/or training purposes (i.e. clinical supervision, conference presentations) and only with prior written permission, may be used by Building Blocks Pediatrics, LLC for marketing purposes**.** Your child's name and information will always be kept confidential. I give permission for my child to be photographed/videod by Building Blocks Pediatrics, LLC.

Child's Name: ____

Parent/Legal Guardian Printed Name: ____

Parent/Legal Guardian Signature: ____

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Patient Attendance Policy

At Building Blocks Pediatrics, our greatest desire is to deliver the highest level of care to our patients. To maximize the benefits of therapy, consistent attendance is critical. Patient commitment to attend therapy as scheduled leads to better potential for patient progress. Missed and tardy appointments slow your child's progress and disrupt schedules. **We require an attendance rate of 75%**. We track visits and will notify you when attendance drops below this requirement.

We strive to be reasonably flexible to schedule changes, conflicts or sudden onset of illness. We request that you inform the front office of cancellations no later than 24 hours prior to a scheduled session. Any patient cancellations of less than 24 hours will apply to the required attendance rate of 75%. If you are more than 10 minutes late for a therapy session your child may not be seen that day, and it will be considered a "no show".

If you are planning to miss more than two weeks of scheduled therapy, **we are unable to hold a weekly spot for your child.** Please let our front office know of any extended vacations or long-term absences.

Two consecutive no-shows or attendance below 75% will result in the removal of your child from their weekly therapy slot.

If you need to discontinue services, please provide us notice two weeks in advance so that our therapists can finalize treatment plans and complete any necessary documentation.

By initialing each item listed and signing below, you are indicating that you fully understand the attendance policy. We anticipate that you will adhere to the following:

_________ 1. If I need to cancel an appointment, I agree to call at least 24 hours in advance. I understand that if I call after business hours, I may leave a voicemail with my child's first and last name, date of birth, therapy type (OT/PT/ST) and reason for cancellation.

_________ 2. I understand that missing an appointment without calling ahead is considered a "no show." I understand that calling within an hour of the appointment is still considered a "no show." I understand that after two "no shows**" my child will be removed from the schedule**.

_________ 3. I understand that if I arrive ten or more minutes late, I may not be seen that day. It will be considered a "no show."

_________ 4. To avoid a "no show" I will refrain from scheduling other appointments around my child's scheduled therapy time.

_________ 5. I understand that my referring physician will be notified if I am removed from the schedule due to inconsistent attendance.

_________ 6. I understand that if my child is seen for two or more therapies on the same day and one therapist must cancel, I am still responsible for bringing my child to his/her other scheduled therapies.

_________ 7. I understand and will follow the treatment plan laid out by the therapists and approved by the referring physician, at home. The home exercise program is very important key to patient progress.

Child's Name: ____ DOB: ___________________________

Parent/Legal Guardian Printed Name: ____

Parent/Legal Guardian Signature: _________________________________ Date: _______________

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Automatic Payment Authorization Form

The Automatic Payment Authorization plan is designed for your convenience. By completing the form below your monthly balance will automatically get process by our billing department and you will receive a copy of your paid statement by email.

I _________________________________ (parent/legal guardian) of ___________________________ (child), hereby choose to participate in the *Automatic Payment Program* and authorize Building Blocks Pediatrics, LLC to bill my credit card on file for monthly charges at the end of each month. I understand that payment will be automatically applied once my monthly statement is generated. I will receive a copy of my statement which will reflect my paid charges and resultant balance after successful payment has been made. In the event of an unsuccessful automatic payment, I agree to pay all charges and any associated fees within 15 days of the date on my statement, and fully understand that any decline in payment from my credit card company can result in the immediate suspension of this agreement. I also understand that this agreement can be terminated at any time by contacting Building Blocks Pediatrics.

(Please type or write legibly)

Printed Name: ____________________________________

Signature: ____

Date: ____

Phone Number: ____________________________________

Email Address: ____________________________________

Credit Card (Check One): ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Credit Card Number: ____

Name of Cardholder: ____

Expiration Date: _______________________

CVV code (3 or 4-digit): _______________

Billing Zip Code: _______________________