Building Blocks Pediatrics LLC
THERAPY AT ITS BEST
ATLANTA · BUCKHEAD · MARIETTA

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:
   - **SIGNED** Patient Service Agreement
   - **SIGNED** Patient Authorizations and Permissions
   - **SIGNED** Patient Attendance Policy
   - **SIGNED** Acknowledgement receipt of the Notice of Privacy Practices
   - **SIGNED** Automatic Payment Authorization.

2. **(REQUIRED) PRESCRIPTION for THERAPY SERVICES**: please have your child's healthcare provider fax 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 the following:**
   - A copy of your child's insurance card
   - A copy of the parent/guardian Photo ID

4. **(If Applicable) UPLOAD the following:**
   - Current OT/PT/ST evaluations (within the past 12 months),
   - Pertinent medical information which will assist us in your child's therapy treatment
   - Current IEP and/or IFSP (within the past 12 months).

Our Clinic Locations

East Cobb (Marietta)
1230 Johnson Ferry Place, Ste G-10
Marietta, GA 30068

Buckhead (Atlanta)
267 West Wieuca Rd NE, Ste 101
Atlanta, GA 30342

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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.

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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 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.

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 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 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 it 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

Your balance can be automatically paid monthly, and a copy of your paid statement will be emailed to you.

I _____, parent of _____, 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, LLC at 770-321-6705.

(Please type or write legibly)

Date: _____

Printed Name: _____

Signature: _____

Phone Number: _____

Preferred Email Addres: _____

Credit Card (circle one): Visa / MasterCard / Discover / American Express

Credit Card Number: _____

Name of Cardholder: _____

Expiration Date: _____

CVV code (3 or 4-digit): _____

Billing Zip Code: _____

Building Blocks Pediatrics, LLC