Growing Places Therapy Services
P: 512.828.7661
F: 512.535.6786
www.growingplacestherapy.com

New Patient Paperwork

The following forms are required to begin therapy services for your child. Therapy cannot begin until these forms are returned, so please complete and return as soon as possible. You may email the forms back to dlevine@growingplacestherapy.com or fax them to us at 512-535-6786.

- **New Patient Intake Form**
  - Please fill-in this form. This form allows us to obtain your demographic information, insurance, and medical history.
- **Consent Form**
  - Please complete the top portion and sign your name at the bottom. This form allows us to treat your child, bill your insurance company, and release medical records to your child's physicians
- **Privacy Practices**
  - Please sign this form at the bottom. This form explains how Growing Places Therapy will disclose your health information and how you can access that information
- **Financial Policy**
  - Please initial, sign, and date this form. This form explains your financial responsibilities.
- **Patient Rights and Responsibilities**
  - This form is for your records only and does not need to be signed or returned.

We look forward to working with your family. Please contact Doug Levine at any time for questions regarding the intake process. He can be contacted at 512.828.7661 or via e-mail at dlevine@growingplacestherapy.com

Thank you!

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Intake Form

Demographic Info			
Child's Name:	DOB:	Social Security #: (Used for Insurance)	
Address:	City:	State:	Zip:
Parent 1 Name: Home phone: Cell phone: E-Mail:	Parent 2 Name: Home phone: Cell phone: E-Mail:		
Insurance Information			
Primary Insurance:	Policy #:	Group #:	Phone #:
Policy Holder' Name:	DOB:	Employer:	
Secondary Insurance:	Policy #:	Group #:	Phone #:
Policy Holder' Name:	DOB:	Employer:	
Tertiary Insurance:	Policy #:	Group #:	Phone #:
Policy Holder's Name:	DOB:	Employer:	
Physician Information			
Name:	Phone #:	Fax #:	
Reason for referral:	Do you have a script:		
History			
Diagnosis:	Allergies:	Medications:	
Reason for therapy/concerns:	Has your child had therapy before: Yes No	Where:	When was the last date seen for therapy?
School district:	School Therapy: Yes No	What kind: PT OT ST	Name of therapist(s):

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Consent Form

Patient's Name: _____

Consent for Release of Records:

I, _____ (patient or representative as signed below), have been informed that each Growing Places Therapy Services, PLLC practitioner is licensed and certified to provide therapeutic services according to the Plan of Care established by the therapist. I accept treatment from Growing Places Therapy Services, PLLC practitioner(s). I can call Growing Places Therapy Services, PLLC regarding my health care at 512-587-5671. This is not an emergency line. Call 911 in an emergency. It is the policy of Growing Places Therapy Services, PLLC to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I authorize Growing Places Therapy Services, PLLC practitioner(s) to release medical information to my physician, the facility of my choice, payer source, or accrediting/regulatory/consulting organizations as appropriate. I authorize the release of the Plan of Care and Discharge Summary upon my transfer to another health care provider.

Financial Authorization:

I authorize benefits to be made on my behalf,

Bill Medicaid	_____%	Medicaid # _____	Effective Date: _____
Bill Primary Insurance	_____%	Insurance Co_____	
Bill Secondary Insurance of	_____%	Insurance Co_____	
Bill Patient co-payment	$_____	Payment per session_____	

I am responsible to inform my Growing Places Therapy Services, PLLC practitioner(s) if my health plan benefits change within 7 days of the change. If HMO refuses coverage, I am responsible for the Growing Places Therapy Services, PLLC practitioner(s) charges incurred. I will pay any service or supply charge not reimbursed by my insurance company on a monthly basis. I will pay all charges incurred on a monthly basis if I do not have insurance coverage. If a claim is denied for Growing Places Therapy Services, PLLC practitioner(s) services which have been submitted on my behalf, I hereby elect not to appeal the denial myself, but I do authorize Growing Places Therapy Services, PLLC practitioner(s) & contractors to resubmit the claim for me and represent me in any negotiations. If client's home is outside of the Austin area, Growing Places Therapy Services, PLLC reserves the right to charge up to an additional $35 to compensate for additional time and travel incurred.

Frequency of Services:

I understand the recommended frequency of services. This frequency may change according to need.

Rights and Responsibilities:

I have received a copy and an explanation of my Bill of Rights.

Complaint/Hotline:

I have been notified of my right to voice a complaint and understand that I may first file a complaint with the Administrator or designee at 512-587-5671. I can also contact the Texas Department of Health, 1100 West 49th St/Austin, Texas 78756; 1-888-973-0022 in the event that I need information or if a complaint is not resolved. The line is open 24 hours a day. This includes a complaint regarding advance directives. Complaints regarding Utilization Review or HMO services can be made directly to TX Dept of Health Insurance at P.O. Box 149091; Austin, TX 78714; 1-800-252-3439.

Procedures:

I understand that it is my right and responsibility to be involved in my care/the care of my child and that I will be informed as to the nature and purpose of any technical procedure. HIPAA – I acknowledge that I have been given the opportunity to review and offered a copy of the Growing Places Therapy Services, PLLC "Notice of Privacy Practices" and consent to the Growing Places Therapy Services, PLLC practitioner(s) use and/or disclosure of protected health information for payment, treatment, and agencies health care operations.

_____	_____	_____
Patient or Authorized Representative Signature/relationship	Date	Reason patient unable to sign

_____	_____
Agency Representative Signature	Date

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Financial Responsibility for Self-Pay Patients

I understand that the services provided to me or my child will be done so as self-pay. The services will not be billed to any insurance company by Growing Places Therapy Services, PLLC and I will be responsible for directly providing compensation to Growing Places Therapy Services, PLLC at the agreed upon self-pay rate on the consent form. The compensation will be provided to Growing Places Therapy Services, PLLC within 60 days of the service or therapy may be put on hold or discontinued until payment arrangements are made.

I have read and understand Growing Places Therapy Services, PLLC's financial policy.

I accept responsibility for any and all costs.

_____ _____ _____

Patient or Authorized Representative Signature/relationship Date Reason patient unable to sign

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www.growingplacestherapy.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW GROWING PLACES THERAPY SERVICES, PLLC MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Growing Places Therapy Services, PLLC respects the privacy of your personal health information and is committed to maintaining the confidentiality of your information. This Notice applies to all information and records related to our patient (and the parent or guardian of a minor patient) care that our facility has received or created. It extends to information received or created by all of our Service Providers. This Notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and our obligations regarding your personal health information.

Growing Places Therapy Services, PLLC is required by law to:

- maintain the privacy of your protected health information. This information consists of all records related to the patient's health, including demographic information, either created by Growing Places Therapy Services, PLLC or received by Growing Places Therapy Services, PLLC from other healthcare providers.
- provide notice of our legal duties and privacy practices with respect to protected health information. These legal duties and privacy practices are described in this Notice.
- abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of the protected health information.

Growing Places Therapy Services, PLLC reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Protected Health Information not Requiring Patient Consent

Growing Places Therapy Services, PLLC may use and disclose protected health information, without the patient's written consent or authorization, for certain treatment, payment and healthcare operations.

Treatment may include:
• Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
• Consultations between healthcare providers concerning a patient;
• Referrals to other providers for treatment;
• Referrals to nursing homes, foster care homes, or home health agencies.
For example, Growing Places Therapy Services, PLLC may determine that you require the services of a specialist. In referring you to another doctor, Growing Places Therapy Services, PLLC may share or transfer your healthcare information to that doctor.

Payment may include:
• Activities undertaken by Growing Places Therapy Services, PLLC to obtain reimbursement for services provided;
• Determining eligibility for benefits or health insurance coverage;
• Managing claims and contacting anyinsurance company regarding payment;
• Collection activities to obtain payment for services provided;
• Reviewing healthcare services and discussing with an insurance company the medical necessity of certain services or procedures, coverage under the patient's health plan, appropriateness of care, or justification of charges;
• Obtaining pre-certification and re-authorization of services to be provided.
For example, Growing Places Therapy Services, PLLC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare Operations may include
• Contacting healthcare providers and patients with information about treatment alternatives;
• Conducting quality assessment and improvement activities;
• Conducting outcomes evaluation and development of clinical guidelines;
• Protocol development, case management, or care coordination;
• Conducting or arranging for medical review, legal services and auditing functions.
For example, Growing Places Therapy Services, PLLC may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES

Growing Places Therapy Services, PLLC may contact, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may disclose protected health information to family members and friends who may be involved with your treatment or care. Health information will be released to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Growing Places Therapy Services, PLLC is permitted or required to use or disclose your protected health information without consent or authorization. Examples include the following:

• As permitted or required by law.
In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

• For public health activities.
We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency.

• For health oversight activities.
We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation and facility or individual licensure of certification.

• Judicial and Administrative Proceedings.
Patient healthcare records, including treatment records and HIV results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

• For activities related to death.
We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death.

• For research.
Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

• To avoid a serious threat to health or safety.
We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

• For workers' compensation
We may disclose health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Growing Places Therapy Services, PLLC will not make any other use or disclosure of protected health information without written authorization. The patient (or a minor patient's parent or legal guardian) may revoke such authorization at any time, except to the extent that Growing Places Therapy Services, PLLC has taken action in reliance thereon. Any revocation must be in writing.

Patient Rights Regarding Protected Health Information

The patient is permitted to request that restrictions be placed on certain uses or disclosures of protected health information by Growing Places Therapy Services, PLLC to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating the patient. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

A patient has the right to review and/or obtain a copy of his or her healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Growing Places Therapy Services, PLLC may deny an access under other circumstances, in which case the patient has the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

A patient may request that Growing Places Therapy Services, PLLC send protected health information, including billing information, to you by alternative means or to alternative locations. He or she may also request that Growing Places Therapy Services, PLLC not send

information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests.

A patient has the right to request that Growing Places Therapy Services, PLLC amend portions of his or her healthcare records, as long as such information is maintained by us. This request must be submitted in writing, and under certain circumstances the request may be denied.

A patient may request to receive an accounting of the disclosures of protected health information made by Growing Places Therapy Services, PLLC for the six years prior to the date of the request. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

A patient has the right to obtain a paper copy of our Notice of Privacy Practices upon request.

Any person or patient may file a complaint with Growing Places Therapy Services, PLLC and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Growing Places Therapy Services, PLLC, please contact the Privacy Officer at the following:

Doug Levine
Growing Places Therapy Services, PLLC
2100 Westfalian Trail
Austin, Texas 78732

It is the policy of Growing Places Therapy Services, PLLC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective June 15, 2006

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of Growing Places Therapy Services, PLLC

Notice of Privacy Practices.

_____ _____

Patient or Authorized Representative Signature/relationship Date

Growing Places Therapy Services, PLLC

by _____ _____

Date

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PATIENT RIGHTS AND RESPONSIBILITIES

Patients have both rights and responsibilities when it comes to their health and the health care services they receive. Parents assume these rights for their children. All Patients receiving care and treatment through Growing Places Therapy Services, PLLC and its contracted parties will be informed of their rights and responsibilities. Copies of patient rights and responsibilities will be provided upon initial assessment of each patient, and can also be obtained at any time by you or your child is being treated through your/your child's therapist. All staff associated or contracted with Growing Places Therapy Services, PLLC will receive education during orientation and annually thereafter explaining patient rights and responsibilities, their role in supporting those rights, and ethical issues.
The following list of patient rights and responsibilities have been set forth to facilitate mutual cooperation, effective communication, effective therapeutic intervention, and a trusting relationship for all staff and for all patients while receiving services through Growing Places Therapy Services, PLLC.

Definitions:

- Patient refers to the individual receiving services, a parental representative or a legal guardian if the patient is under the age of 16, or is an adult unable to understand rights and responsibilities.
- Service Provider will be used to indicate Growing Places Therapy Services, PLLC or its contracted parties
- Setting may refer to the patient's home, daycare, Head Start Center, or parent/patient choice of location where services may be rendered
- Service pertains to the collection of information, verbal contact/consultation, and delivery of therapeutic intervention as prescribed by your physician

Growing Places Therapy Services, PLLC has adopted the general responsibilities of The Consumer Bill of Rights as sponsored by the Federal government.

Patients' Bill of Rights

I. Information Disclosure
You have the right to receive accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, assistance will be provided so you can make informed health care decisions.

II. Choice of Providers and Plans
You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality health care.

III. Access to Emergency Services
If you have sever pain, an injury, or sudden illness that convinces you that your health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

IV. Participation in Treatment Decisions
You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions.

V. Respect and Nondiscrimination
You have a right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives, and other health care providers.

VI. Confidentiality of Health Information
You have the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.

VII. Complaints and Appeals
You have the right to a fair, fast, and objective review of any compliant you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.

In addition to following the Consumer Bill of Rights Growing Places Therapy Services, PLLC also employs the following list of Patient Responsibilities to further insure mutual cooperation, effective communication, effective therapeutic intervention, and a trusting relationship for all staff and for all patients while receiving services through Growing Places Therapy Services, PLLC.

Patient Responsibilities

All persons receiving treatment through Growing Places Therapy Services, PLLC have the responsibility to:

1. Participate in the development of treatment plans and to collaborate with staff in working towards rehabilitation goals.

2. Show respect for the rights of other patients and staff.

3 Abide by the rules and expectations of the centre.

4 . Not use non prescribed drugs or alcohol.

5. Not distribute or sell drugs or alcohol.

6. Not be in possession of dangerous weapons.

7. Co-operate by providing information on past illnesses, hospitalizations, medications or other matters relating to their condition.

8. Seek information and ask questions essential to making decisions regarding their care.

9. Respect the property of other patients, staff and the hospital. They may be held liable for any loss or damages incurred.

10. Be courteous to include insuring your child or other children present do not misbehave and show respect to staff, materials, and procedures.

11. Be responsible for their personal hygiene and belongings to the extent that their disability allows.

12. Keep scheduled appointments or notify the appropriate personnel when unable to do so.

Lastly, Growing Places Therapy Services, PLLC applies responsibilities to its contracted parties to insure mutual cooperation, effective communication, effective therapeutic intervention, and a trusting relationship for all staff and for all patients while receiving services through Growing Places Therapy Services, PLLC.

Responsibilities of Service Provider

1. The service provider will ascertain that the patient knows and demonstrates understanding of their responsibilities as a patient by providing instruction and information in the patient's primary language either through verbal or written communication and employing the services of an interpreter when required.

2. A planned approach will be coordinated with the service provider and the patient/family to encourage appropriate patient behavior to facilitate service delivery and progress towards goals.

3. The service provider will issue a verbal warning for the first violation of rules and regulations to adolescent patients, the parent of younger patients or the legal guardian of younger patients. This verbal warning will be issued by the primary service provider when and if the service provider is undergoing needed supervision to fulfill regulations for discipline specific licensure as required by the State of Texas.

4. For repeated violations, the service provider will set a discharge date for the patient that will ensure adequate notice or time for corrective action to occur. The primary physician will be notified by the service provider at the time of discharge. In this situation that pertains to infants, children, or adolescent patients the parents or legal guardians will be given all due consideration, explanation, and legal consents as representatives of these patients. This shall include all situations where conflicts occur and mediation is necessary. Consideration shall be given to include the adolescent in decisions where his or her level of understanding is deemed appropriate.