# Building Hope

## Therapy Services LLC

Dear Family,

Welcome to Building Hope Therapy Services, LLC. We are passionate about helping children and their families grow! We are so honored you have chosen to work with us!

Inside this packet, you will find:

- Child Intake form
- Physician Referral form
- Consent to Bill Health Insurance form
- Financial Responsibility Agreement
- Privacy Practices Statement
- Authorization for Treatment

Steps you need to complete:

1. Call your pediatrician and ask them for a "Physician Referral for an Occupational Therapy Evaluation and Treatment". You may share the referral form found in the packet or the pediatrician may have a form they like to use. Either option is ok.
2. Complete the Child Intake form, Consent to Bill Health Insurance form, Financial Responsibility Agreement, Authorization for Treatment and return them to us prior to your first visit along with any other information/records you feel is important to share. (Examples may be IEPs, Care Plans, Medical History etc.)
3. Review the Practice Practices Statement at your leisure.
4. Contact us with any questions you have!

Steps we will complete:

1. Contact you to schedule an Initial Evaluation, (this usually lasts between 30 minutes to One hour)
2. Review paperwork
3. Prepare for a fun and growth centered visit for the child and you!

Please contact us with ANY questions! We cannot wait to start this journey with you!

Kindest Regards,

Amanda Kletti, M.S. OTR/L

Building Hope
Therapy Services LLC

N9654 County Road N Suite 3
Appleton, WI 54915
Phone: (920) 202-2262
Fax: 414-921-5636
Amanda.buidlinghope@gmail.com

# Child Intake Form

Welcome to Building Hope Therapy Services, LLC.! We look forward to the opportunity to collaborate in your child's growth and development. Please complete the attached paperwork so we may best serve you. **Completion of this paperwork allows the evaluating staff the opportunity to familiarize themselves with your child and select appropriate assessment materials and activities.**

**Thank you for your cooperation!**

Today's Date: _____ Individual Completing Form: _____

☐ Checking this box confirms that my first and last name above constitute my legal name when used in my signature throughout this document.

Client's Name: _____ Client's Date of Birth: _____
Client's Sex & Gender: _____
Client's Address: _____
City: _____ State: _____ Zip: _____
Preferred Phone Number:(_____) _____-_____

Whom may we thank for referring you? _____

Primary Concerns/Goal Areas:

Please list any conditions your child has been diagnosed with.

**PATIENT INFORMATION**

Client's Name: _____

Person to Contact in Case of Emergency: _____

Relationship to Client: _____

Phone:(_____) _____-_____

**RESPONSIBLE PARTIES**

**1.**Name: _____

Relationship to Client: _____

☐ This party is a legal guardian of this client.

(Notes: _____)

Address: ☐ Same as Client's

_____

City: _____ State: ____ Zip:_____

Cell Phone:(_____) _____-_____

E-Mail: _____

Employer: _____

Work Phone:(_____) _____-_____

**2.** Name: _____

Relationship to Client: _____

☐ This party is a legal guardian of this client.

(Notes: _____)

Address: ☐ Same as Client's

_____

City: _____ State: ____ Zip:_____

Cell Phone:(_____) _____-_____

E-Mail: _____

Employer: _____

Work Phone:(_____) _____-_____

**May we add you to our mailing list?** ☐ Yes ☐ No, thanks.

# PATIENT HISTORY

SOCIAL/FAMILY HISTORY
Who lives in the client's home? Please include sibling names and ages.

Do any family members have syndromes, delays, or other diagnoses?

Primary Language Spoken in Home:

PREGNANCY & BIRTH HISTORY
Did any illness or trauma occur during pregnancy?

Were there any concerns at birth?

My child was adopted at age _____, and their country of origin is _____

MEDICAL & DEVELOPMENTAL HISTORY
Please list any ALLERGIES, DIETARY RESTRICTIONS, OR SPECIFIC MEDICAL CONCERNS (e.g., nuts, bee stings, medications, gluten/casein, soy, seizures, precautions):

☐ My child does not have any known allergies, dietary restrictions, or medical concerns.

Please list any medications your child is currently taking and the reason(s) for those medications.

Have the following milestones been met? Please indicate at what ages.
☐ My child met all of their developmental milestones within normal limits.

| Milestone | Head Control | Walking | Rolling | Unsupported Sitting |
|---|---|---|---|---|
| Age Met | | | | |
| Notes | | | | |

| Milestone | Toilet Trained | First Words | Crawling | Fed Self with Spoon |
|---|---|---|---|---|
| Age Met | | | | |
| Notes | | | | |

## TREATMENT HISTORY

Please describe any services your child has received to date (e.g., Birth to Three, Early Childhood, outpatient OT/PT/SLP, audiology, intensive in-home autism therapy, complementary/alternative medicine, Intensive Model of Therapy/IMOT).

Have your child's vision and hearing been tested recently? If so, what were the results?

Please list any significant illnesses, hospitalizations, surgeries, medical procedures, etc. Please include age, frequency, severity, and method of treatment(s).

## EDUCATIONAL HISTORY

Current School/Daycare Facility: _____ Grade: _____
City: _____ Primary Teacher's Name: _____

Is your child frequently absent from school? If so, why? _____

How does your child feel about his/her teachers? _____
Does your child receive any special services from the school district?
IEP 504 N/A

**If so, please submit a copy of your child's most recent IEP or 504**

## SPEECH & LANGUAGE

Please describe any specific needs related to your child's speech, language, and communication skills.

## EATING/FEEDING

Please describe any specific needs related to your child's eating or feeding skills.

## SENSORY PROCESSING

Please describe any specific needs related to your child's sensory processing.

## SELF-CARE

Please describe any specific needs related to your child's self-care skills.

## FINE MOTOR

Please describe any specific needs related to your child's fine motor skills.

## GROSS MOTOR

Please describe any specific needs related to your child's gross motor skills.

## EDUCATIONAL

Please describe any specific needs related to your child's academic skills.

## EQUIPMENT

Please describe any specific equipment used to support your child's needs

## CLIENT INTERESTS

Please describe your child's interests (e.g., toys, books, games, movies/shows, activities, music).

## CULTURAL/RELIGIOUS INFORMATION

We are all different! Please elaborate on any traditions or information unique to your family's culture and/or religion so we may respectfully acknowledge those differences as we engage with your child.

## ADDITIONAL INFORMATION

Please include any additional details about your child's needs and unique abilities.

# Physician Referral Form

Please Fax your referral to: 414-921-5636

Building Hope
Therapy Services LLC

**Patient Name:** _____

**Patient DOB:** _____

**Diagnosis/ Notes:** _____

**ICD-10 Code:**

_____

**Frequency & Duration:**

☐ 1x/week for 3 months

☐ 2x/week for 3 months

**Contraindications/Precautions**:

_____

---

☐ **Occupational Therapy Evaluation**

☐ **Occupational Therapy Treatment**

**Additional Comments:**

_____

_____

Physician Name & Practice Location:

Physician Signature: Date:

**Financial Responsibility and Authorization to Pay**
**Building Hope Therapy Services, LLC.**

I hereby authorize my insurance benefits to be paid directly to Building Hope Therapy Services, LLC. I understand that I am financially responsible for all amounts not covered by insurance, including deductibles, co-payments, and continued treatment and services when insurance benefits are exhausted or if benefits are denied at any point during rehabilitation. I authorize Building Hope Therapy Services, LLC to release any information necessary to process my medical claim, I understand that charges for all services provided to me or my child/children by Building Hope Therapy Services, LLC which are not covered by insurance are my personal responsibility. My signature below constitutes my agreement to pay for such services. I acknowledge that I am responsible for payment for all services that my insurance does not cover and that it is my responsibility (and not Building Hope Therapy Service's responsibility) to know and understand the extent of my health insurance coverage. Payment is required at the time of service for co-payments and deductibles. Should there be a remaining balance after your insurance company has paid their portion; uncovered amounts shall be paid within 30 days of the date of the billing statement. After 30 days, a late fee of $20 per month will be assessed. After 60 days, your account may be transferred to a collection agency. The fee for a returned check is $25 in addition to the amount of the check. This charge covers our bank fees as well as additional processing and billing costs. As a service to you, we will bill your insurance carrier. We will make two (2) attempts to bill and re-bill for the correct payment. Should our efforts be unsuccessful, you will be responsible to pay for the services. We will provide you with the forms and codes needed for you to try to obtain reimbursement from your insurance carrier. An appointment cancellation fee of $50.00 will be charged for appointments cancelled less than 24 hours prior to the scheduled appointment time. In the event it is necessary to assign the account to a collection agency or if legal action is necessary to enforce the terms of this agreement, I agree to be responsible for all fees and costs incurred by Building Hope Therapy Services, LLC., including attorney's fees. My signature below constitutes agreement to adhere to the financial responsibilities outlined in this agreement.

_____ _____

Signature of patient or responsible party Date

Print Name


**NOTICE OF PRIVACY PRACTICES**

**Effective date: January 1st, 2015**

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPAA). It describes how I may use or disclose your child's protected health information, with whom that information may be shared, and the safeguards I have in place to protect it. This notice also describes your' rights to access and or refuse the release of specific information outside of this system except when the release is required or authorized by law or regulation.

**Acknowledgement of Receipt of this Notice**

You will be asked to provide a signed acknowledgement of receipt of this notice. The intent is to make you aware of the possible uses and disclosures of your child's protected health information and your privacy rights. The delivery of your child's health care services will in no way be conditioned upon your signed acknowledgement.

**Who Will Follow this Notice**

This notice applies to all therapy services provided by BUILDING HOPE THERAPY SERVICES LLC. It also applies to office personnel and billing personnel.

**Our Responsibility Regarding Protected Health Information**

Your child's 'protected health information' is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your child's past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

- Make sure that your child's protected health information is kept private
- Give you this notice of our legal duties and privacy practices related to the use and disclosures of your child's protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about your child as well as any information received in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the top of this notice.

**Our system**

Amanda Kletti MS OTR/L works with several agencies and referral sources. Your child's health information will be shared in the following manner:

1. Treatment- I will use and disclose your child's protected health information to provide, coordinate, or manage your child's health care and any related services. This includes disclosure to your physician or other health care providers who becomes involved in your child's care.
2. Within my office for administrative activities, quality assessment, oversight and peer review
3. With my billing personnel and as necessary to obtain payment for your health care services.
4. With your insurance company or other payers as required for payment.
5. With the referring agency and case manager, if applicable.
6. With any other provider, school, or agency with your written request. You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

**Required by Law**

I may use or disclose your child's protected health information if law or regulation requires the use or disclosure.

I will notify the appropriate government authority if I believe a patient has been the victim of abuse, neglect, or domestic violence.

**Health Oversight**

I may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

**Legal Proceedings**

I may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

**Parental Access**

I may disclose your child's protected information to parents, guardians and persons acting in similar legal status.

**Uses and Disclosures of Protected Health Information Requiring Your Permission**

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your child's protected health information.

Since this service is provided in your home or other natural environments, those present during the session, including friends, family, or day care providers may hear health information regarding your child. Please notify your therapist if you do not want your child's protected health information to be discussed.

**Your Rights Regarding Your Child's Health Information**

You may exercise the following rights by submitting a written request to the BUILDING HOPE THERAPY SERVICES LLC office.

1. You may inspect and obtain a copy of your child's protected health information that is kept as a part of medical and billing records.

2. You may ask me not to use or disclose any part of your child's health information for treatment, payment, or health care operations. Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm your child.
3. You may request that I communicate with you using alternative means or at an alternative location. I will not ask you the reason for your request. I will accommodate reasonable requests, when possible.
4. If you believe that the information I have about your child is incorrect or incomplete, you may request an amendment to your child's protected health information as long as I are responsible for and maintain this information. While I will accept requests for amendment, I am not required to agree to the amendment.
5. You may request that I provide you with an accounting of the disclosures I have made of your child's protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. This disclosure must have been made after January 1st, 2015, and no more than six years from the date of request. This right excludes disclosures made to you or authorized by you, to family members or friends involved with your child's care, or for notification. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this notice.

**Federal Privacy Laws**

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing policies and this notice of how I will use and disclose your child's protected information.

**Complaints**

If you believe these privacy rights have been violated, you may file a written complaint with the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

**This notice is effective in its entirety as of January 1st, 2015.**

N9654 County Road N Suite 3

Appleton, WI 54915

(920)202-2262

Amanda.buidlinghope@gmail.com

# Authorization for Treatment

Patient Name: Date of Birth:

I, _____ acknowledge and agree to have my child, _____

receive occupational therapy services with any of the therapists at Building Hope Therapy Services. I acknowledge that there is some risk inherent in the use of the therapy equipment. I agree to indemnify and hold any of the therapists at Building Hope Therapy Services harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child, or our belongings.

_____ _____

Signature Date