Abbott & Burkhart Therapy

CLIENT INFORMATION

CLIENT

Legal Name: Last	First	Middle Initial	Birth Date
Street Address			School
City	State	Zip Code	
Emergency Contact	Relationship		Phone Number

Area of Concern:

- ☐ Sensory
- ☐ Cognition
- ☐ Behavior
- ☐ Auditory
- ☐ Tactile
- ☐ Poor Attention
- ☐ Self Help Skills
- ☐ Fine Motor
- ☐ Social Skills
- ☐ Gross Motor
- ☐ Oral Motor
- ☐ Swallowing / Feeding
- ☐ Receptive Language
- ☐ Expressive Language
- ☐ Articulation

PARENTS

Parents:		
Street Address		
City	State	Zip Code
Home Phone	Parent's Cell Phone:	Secondary Cell Phone:
Email:	Email:	

PRIMARY CARE PHYSICIAN

Physician's Name		Specialty
Clinic Name:		
Office Phone		
Date Last Seen	Reason	

PRIMARY INSURANCE

Insurance Name		Effective Date	
Subscriber Name		Birth Date	
Relationship to Client		[redacted] - -	
Subscriber's Employer	Policy#	Co-Pay	Deductible

SECONDARY INSURANCE

Insurance Name		Effective Date	
Subscriber Name		Birth Date	
Relationship to Client		Social Security Number - -	
Subscriber's Employer	Policy#	Co-Pay	Deductible

ADVANCED SCREENING

Allergies: ☐ **YES** ☐ **NO**	LIST ALLERGIES:		
Vaccinated: ☐ **YES** ☐ **NO**	CURRENT VACCINATIONS/IMMUNIZATION RECORD:		
Formal Hearing Evaluation ☐ **YES** ☐ **NO**	When	Where	Results
Formal Vision Evaluation ☐ **YES** ☐ **NO**	When	Where	Results
Adaptive Equipment ☐ **YES** ☐ **NO**	Type	Reason	
Sensory Issues ☐ **YES** ☐ **NO**	If **YES**, please explain		
Attention Issues ☐ **YES** ☐ **NO**	If **YES**, please explain		
Behavior Issues ☐ **YES** ☐ **NO**	If **YES**, please explain		
Feeding Issues ☐ **YES** ☐ **NO**	Picky Eater ☐ **YES** ☐ **NO**	If **YES**, explain	

CONSENT TO

I do hereby consent to such treatment by the authorized personnel of Abbott & Burkhart Therapy as may be dictated by prudent medical practice by my illness, injury, or condition.

_____ _____

Client/Legal Guardian/Parent Signature Relationship to Client

_____

Date

Abbott & Burkhart Therapy

CANCELLATION POLICY

1. Cancellations must be made 24 hours prior to the appointment time. Notification of cancellation of 6 hours or less will be considered a "No Show". If a no-show occurs, a policy reminder letter will be generated and sent via regular first class mail. The letter indicates that the client will be removed from the schedule should another no-show occur and a $50 administrative fee will be implemented.

2. If a second no-show occurs, the client will be removed from the schedule. If therapy is to be resumed, the $50 administrative fee must be paid prior to the treatment session.

3. Multiple cancellations are treated in a similar manner. Cancellations are reviewed over a course of 2 months. Should a client miss greater than 25% of visits in a 2 month period, a policy reminder letter will be generated and sent via regular first class mail. Clients that cancel for vacations, or surgeries, etc are exempt from the 25% rule.

4. If ill, please call and cancel your appointment. We do not want to spread any illness between our clients. If you do not call and we deem that the client is too sick to be seen, we reserve the right to cancel the session.

5. We offer make-up sessions, as they are in the client's best interest. Make-up slots are offered for inclement weather, illness and pre-arranged vacations/holidays. Make-up sessions are not offered when there is a violation of the cancellation policy. For example, if you are charged for a no-show, we will not reschedule that visit. Make-ups may be attempted for holidays, vacations and cancellations, as schedule permits. Make-up sessions may be attempted by another therapist employed at Abbott & Burkhart Therapy operating within the same discipline.

6. In the event you are late 15 minutes or more for your scheduled appointment, call before your session begins. A "No Show" will be considered 15 minutes after the appointment start time and the therapist may leave.

7. Contact the office at 805-650-6290.

OFFICE POLICY

1. It is your responsibility to provide our office with complete and accurate insurance information at each visit. Please present your card for copying so that we may file claims correctly. We must be informed immediately of any changes to your insurance information.

2. It is your responsibility to provide our office with any address or phone number changes.

3. A $10.00 service charge will be added to all balances over 60 days past due.

4. If you have signed advanced directive it is your responsibility to provide our office with a copy for your chart.

FINANCIAL POLICY

1. Clients are responsible for payment of their accounts regardless of insurance coverage. If the Client is a minor, the parent or guardian is responsible.

2. Clients are responsible for costs of collection, including reasonable attorneys' fees and collection agency costs that may be incurred in the collection of any and all indebtedness. If the client is a minor, the parent or guardian is responsible.

THE ABOVE AFOREMENTIONED POLICIES ARE EFFECTIVE IMMEDIATELY. I AM AWARE AND UNDERSTAND THE ABOVE POLICIES.

_____

Client Name

_____ _____

Client/Guardian Signature DATE

NOTICE OF PRIVACY PRACTICES

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of our client's medical information is important to us. We understand that medical information is personal and we are committed to protecting it. We create a record of the care and services clients receive at our organization. We need this record to provide clients with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

The law requires us to keep your medical information private, give this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and follow the terms of the current notice.

We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We also have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Prior to making an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose medical information for any purpose not listed below, without specific written consent. Any specific written consent you provide may be revoked at any time by writing to us.

For Treatment: We may use medical information to provide treatment or services. We may disclose medical information to doctors, educators, service coordinators, or other providers consented by you.

For Payment: We may use and disclose medical information for payment purposes. A bill may be sent to the client or third party payer. The information on or accompanying the bill may include your medical information.

Sign-In Sheet: this practice maintains a sign-in sheet for clients receiving treatment in the clinic. The sign-in sheet is located in a position where staff can readily see who is seeking care, as well as individual's location within the lobby of Abbott & Burkhart Therapy. This information may be seen by, and is accessible to, others who are seeking services at Abbott & Burkhart Therapy.

Scheduling/Appointment Reminders: the therapist assigned to your child may disclose health information to contact you to provide scheduling opportunities and appointment reminders. You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse authorization, it will not affect the treatment we provide to your child.

Additional Uses and Disclosures: In addition to using and disclosing medical information for treatment and payment, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your location or general condition. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for a client's health care, according to our professional judgment. We will also use our professional

judgment to make decisions in your best interest about allowing someone to pick up medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use or disclose medical information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

YOUR RIGHTS

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photos copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or different locations. Your request that we communicate your medical information by different means or location must be made in writing to our Business Administrator.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request to our Business Administrator.

If you have any questions about this notice, please speak to our Business Administrator.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and fully understand Abbott & Burkhart Therapy's Notice of Privacy Practices. I understand that Abbott & Burkhart Therapy may use or disclose my personal medical information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal medical information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Abbott & Burkhart Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Abbott & Burkhart Therapy's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

If client is not capable of acknowledging the notice because of age or medical condition, please complete the following:

Client is a minor (_____years of age) OR Client is unable to acknowledge because

_____

_____ _____

Client Name Client/Guardian Signature

_____

Date

Name of Client: _____

CONSENT TO OBTAIN / RELEASE MEDICAL INFORMATION:

☐ I hereby authorize **Abbott & Burkhart Therapy** to file a claim to my insurance company for services rendered. I further authorize **Abbott & Burkhart Therapy** to release all necessary information to my insurance company, third party payer, or its agents for determination of benefits and completion of insurance claims.

☐ I consent to and authorize **Abbott & Burkhart Therapy** to release any medical and educational records to the following individuals listed below who have provided or are providing medical or educational services to the above named client.

HIPAA

I understand that these records will be used only to coordinate medical and educational services to the above named client and that **Abbott & Burkhart Therapy** protects the confidentiality of client information and releases information only according to the policies based on federal and state law and HIPAA standards. Only persons responsible to the direct care of the above named person are privy to information regarding the above named person.

Name of Primary Physician	**Address/City/Zip**	**Phone Number**
Name of Other Medical Providers	**Address/City/Zip**	**Phone Number**
School District/Educational Agency	**Address/City/Zip**	**Phone Number**
Tri-Counties Service Coordinator	**Address/City/Zip**	**Phone Number**
Other Agencies	**Address/City/Zip**	**Phone Number**

I understand that Consent to release information is valid until the above named client turns 21 years of age. All or part of the consent to release information can be canceled or changed upon receipt of written notifications for the undersigned.

Parent/Guardian Signature: _____ Date: _____

Relationship: _____

Abbott & Burkhart Therapy
1601 Eastman Avenue, Suite 103
Ventura, CA 93003
Phone: 805-650-6290
Fax: 805-650-6912

Thank you for choosing Abbott & Burkhart Therapy as your therapy provider. Please place an "X" indicating your availability.

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00am					
9:00am					
10:00am					
11:00am					
12:00pm					
1: 00pm					
2: 00pm					
3: 00pm					
4: 00pm					
[redacted]					

Child's Name:_____ **Date:** _____

Guardian's Name: _____

SCHEDULING NOTES:

REQUEST FOR ELECTRONIC COMMUNICATIONS

Name of Client: _____

Name of Parent/Guardian: _____

Client Date of Birth: _____

I request that the following communications from Abbott & Burkhart Therapy be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold Abbott & Burkhart Therapy responsible should such an incident occurs.

Communications:

☐ Scheduling/Appointment Reminders ☐ Billing Statements

☐ Report Submissions (Initial Assessments and Progress Summaries)

Method:

☐ Email Email address: _____

☐ Text Cell number: _____

Time Period for this Communication Method: _____

Acknowledgement and Agreements:

I understand and agree that the requested communication method is not secure, making my PHI at risk for receipt by unauthorized individuals. I accept the risk and will not hold Abbott & Burkhart Therapy responsible in any way should this occur:

SIGNED:_____ Date: _____

Print Name: _____ Phone No. _____

Relationship to Client: _____

Abbott & Burkhart Therapy

Informed Consent for Teletherapy

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my therapist wishes me to engage in a telehealth consultation.
2. My therapist explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a **direct conversation** with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY ZOOM

ZOOM is the technology service we will use to conduct telehealth videoconferencing appointments. By signing this document, I acknowledge:

1. ZOOM is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither ZOOM or Abbott & Burkhart Therapy provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. ZOOM facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the ZOOM application – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the ZOOM application.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

1601 Eastman Avenue
Suite 103
Ventura
California 93003
805.650.6290
805.650.6912
www.abtherapy.org

_____ _____

PRINT NAME OF:
Patient/Guardian if client under 18 Date

_____

Signature