Intake Checklist for New Clients:

Please complete all necessary forms:

- Intake Form
- Consent to Share Information Form
- Policies/Procedures Signature and Consent Form
- Electronic Communications Form

Thank you for providing the above information. Please contact us with any questions or concerns.

- Dr. Danielle

Contact Information

Danielle Yeager, OTD, OTR/L
816.401.8309
info@drdanielleds.com
danielle@drdanielleds.com

Dr. Danielle's Developmental Services Policies and Procedures

Welcome!

Dr. Danielle's Developmental Services is a private practice that offers pediatric occupational therapy, speech language, and educational services. Services are offered in the child's home.

Treatment Sessions: Treatment sessions last one hour. The session starts with time for the child to get comfortable and the service provider to be updated on any progress since the last time they saw the child. Then treatment will look like engaging the child in age and developmentally appropriate games, play, and activities based on their goals. The last ten to fifteen minutes of the session are dedicated to closing activities including cleaning up with the child, discussing the session with the caregiver, making recommendations for the week, and writing a brief treatment note.

Physician Referral or Prescription: A physician's referral is not required for your child to begin services, it is recommended that we have one on file especially if you are going to seek reimbursement for OT or SLP services. Please provide us with a written prescription from your child's physician if you are planning on seeking out-of-network insurance reimbursement for OT and/or SLP services. It will be helpful documentation if an insurance company requests proof of medical necessity. **This is not necessary if you are planning on just having private pay without seeking reimbursement.**

Out-of-Network Insurance Clients: We will not submit claims to insurance companies. However, we will include all necessary information, including tax ID as well as proper insurance coding, on invoices. This will allow you to submit the invoice to your insurance company to seek reimbursement. You will be expected to pay your bill in full regardless of if or when your insurance reimburses you. See payment next.

Private Pay Clients: We will bill you monthly for services. You will receive an invoice within the first 2 weeks of the following month via e-mail. A hard copy of the invoice will be either provided either in the mail or at a treatment session. Payment is due within 2 weeks of the invoice date. You can pay via cash, check, or credit card. Payments not received within 30 days of the invoice date will be assessed a 5**%** late fee. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Missed appointments: If your child is ill, you need to cancel a visit, or you are running late to a session, please feel free to call or text your service provider to let them know. Please give at least 24-hour notice for cancellations.

We understand that in cases of illness or emergency, 24 hours notice may not be possible. Our policy is to charge a $25.00 fee for any missed appointments without a cancellation. This includes no-show visits. Please note that this $25.00 fee cannot be reimbursed by your insurance, and you will be responsible for this charge.

In the event of severe weather your service provider will contact you as soon as a decision about cancellation is made. If your service provider has to cancel they will make every attempt possible to reschedule at a time of your convenience.

Privacy Policy: Please review our Notice of Privacy Practices as required by HIPAA.

Thank you for reading our policies. Please let us know if you have questions or concerns about any of the above information.

Notice of Privacy Practices

Effective January 1st, 2019 This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). 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 acknowledgment 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 acknowledgment.

Who Will Follow this Notice - This notice applies to all therapy services provided by Dr. Danielle's Developmental Services. 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 is related 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 disclosure 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. It's 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 request a Notice of Privacy Practices at any time.

Dr. Danielle's Developmental Services works with several agencies and referral sources. Your child's health information will be shared in the following manner:

1. Treatment - We 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 sharing treatment information across the team at Dr. Danielle's Developmental Service.
2. With your insurance company if you seek out of network reimbursement, or other payers as required for payment.
3. With the referring personnel, if applicable.
4. 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

- We may use or disclose your child's protected health information if law or regulation requires the use or disclosure.
- We will notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Parental Access - We may disclose your child's protected information to parents, legal guardians, and persons acting in a 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 service provider 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 Dr. Danielle's Developmental Services.

1. You may inspect and obtain a copy of your child's protected health information that is kept as a part of medical records.
2. You may ask us 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 we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable request, when possible.
4. If you believe that the information we have about your child is incorrect or incomplete, you may request an amendment to your child's protected health information as long as Dr. Danielle's Developmental Services is responsible for maintaining this information. While we will accept requests for amendment, we are not required to agree to the amendment.
5. You may request that we provide you with an accounting of the disclosures Dr. Danielle's Developmental Services has 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 April 21, 2010, 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 in 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 Dr. Danielle’s Developmental Services 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, 2019.

Policies/Procedures Signature and Consent Form

Child's Name: _____

Child's DOB: _____

Dr. Danielle's Developmental Services Policies & Procedures I have read, understand and accept the terms of the above policy statements including **Billing Policies & Procedures and Missed Appointments.**

Parent/Guardian Signature: _____

Date : _____

Dr. Danielle's Developmental Services Privacy Policy I have been given a copy of Dr. Danielle's Developmental Services Notice of Privacy Practices. I will review it, and keep it on file.

Parent/Guardian Signature: _____

Date : _____

Dr. Danielle's Developmental Services Consent to Evaluation and/or Treatment I consent to necessary examination procedures and/or treatment for my child by Dr. Danielle's Developmental Services.

Parent/Guardian Signature: _____

Date : _____

Intake Form

Date: _____/_____/_____

Child's Information

Child's Name: _____ Birth date: ___/___/___
Gender: *Male* *Female* *Non-Binary*

Address:

_____

City: _____ State _____

Zip _____

Phone Number:_____

Cell? Y N

Who's Number:_____

Phone Number:_____

Cell? Y N

Who's Number:_____

Phone Number :_____

Cell? Y N

Who's Number:_____

Email Address:_____

Family Information

Caregiver's Name: _____ Relationship: _____

Caregiver's Name: _____ Relationship: _____

Caregiver's Name: _____ Relationship:_____

Name and Ages of Siblings Living in Household:

_____

_____

List the names of those living in the household other than the immediate family:

_____

_____

Primary Language(s) spoke in the home:

_____

Educational Information

1. Does your child have a diagnosis? Y N (if "no" move on to the next section)

Diagnosis: _____

Age of Child at Initial Diagnosis: _____ years _____ months

Who made the diagnosis? (e.g. name of professional or agency)

_____

2. Does your child have an IEP? Y N (If "yes" please provide a copy)

School Name: _____
District: _____

Address: _____ City: _____
State: _____ Zip: _____

3. Does your child receive any other therapies, interventions, or services? Y N (if "no," move on to the next section)

Please list any therapies/interventions including agency name and frequency.

_____

_____

_____

Background Information:

Pertinent Medical History (Please include surgeries, prenatal difficulties, or any significant birth difficulties):

Developmental History: (Please include a brief summary of developmental milestones, especially in any area of concern):

Describe your primary concern(s) regarding your child?

At what age did you become concerned?

What do you perceive as your child's strengths?

What activities does your child enjoy doing?

What activities do you and your child enjoy doing together?

What activities does your child struggle with? (e.g. avoids, gets upset, refuses to participate in)

Please share any additional information that might be helpful during the evaluation/treatment process.

Release of Confidential Information

I/We _____ give my/our informed consent for:

Dr. Danielle's Developmental Services, LLC

Service Provider(s) Name(s):

_____
_

to communicate and to share information about _____ in writing and conversation with:

Name:

Position:

Phone:

Number:

E-mail:

Parent/Guardian Signature: _____

Date : _____

Electronic Communication Consent

This Electronic Communication Disclosure and Consent, applies to all communications between _____ and Dr. Danielle's Developmental Services, LLC.

____ I give consent to be emailed information including treatment notes, invoices, and billing that may have sensitive information disclosed. I understand and take responsibility for the risk of this information being seen by an outside party due to the nature of electronic communication.

____ I give consent to using text messages to communicate regarding after session questions and scheduling concerns. I understand and take responsibility for the risk of this information being seen by an outside party due to the nature of electronic communication.

Email address: _____

Phone number: _____

Parent/Guardian Signature: _____

Date : _____