Please provide me, Alysson Goodwin, OTR/L, with some information prior to the start of therapy. The information you provide will help me to better understand your child, and to most effectively meet the needs of your child and your family. Service agreement and privacy policy forms are also provided. Enclosed are the following:

- Registration Form
- HIPAA privacy policy information
- Privacy Policies and Procedures Receipt and Consent
- Parent Policies and Procedures
- Consent to Treat and Bill Insurance

You may keep the Notice of Privacy Policies and Parent Policies and Procedures forms. Please complete the remaining forms, and fax, mail, or scan and email the forms prior to your child's first appointment at:

Alysson Goodwin, OTR/L

29 Race Street

Charleston, SC 29403

Fax: (815) 346-2363

Phone: (843) 284-6278

Alyssongoodwin@yahoo.com

Providing this information as soon as possible prior to your child's session will help me to prepare appropriately for the first meeting with your child. If you have any questions, please call me at (843) 284-6278. I look forward to meeting you!

Registration Form

Alysson Goodwin, OTR/L

29 Race Street
Charleston, SC 29403
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Fax: (815) 346-2363
Alyssongoodwin@yahoo.com

PERSONAL INFORMATION

Child's Name:________________________ Date: __________ Referred by:______________________

Child's Birthdate: ____________ Age: ____________ School: ______________________

Primary caregiver(s):____

Address:____

Other family members in household (include sibling ages); other caregivers:______________________

____

Home Phone: ______________ Cell Phone: ____________ Work Phone: ______________

E-Mail:________________________ Preferred Method of Contact:______________________

MEDICAL INFORMATION

Allergies:________________________ Dietary Restrictions:______________________

Diagnoses (if known):________________ Medications:______________________

Please list any known precautions or physical conditions (seizures, heart problem, asthma, muscle/bone disorder):

____

____

Insurance Plan/Company: ______________________ Primary Insured:______________________

Insurance Group/ Policy Number: ________________ Insured's Birthdate:______________________

Child's Pediatrician: ________________________ Pediatrician's Phone Number:______________

ADDITIONAL INFORMATION

List any additional therapy or services the child is receiving as well as the names of the providers:

____

____

Primary Concerns:

1.____

2.______________________________ ______________________________

3.____

Parent Policies

Alysson Goodwin, OTR/L

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Rates:
(Significant discount provided to cash clients. See rates at bottom of page.)

Evaluation: $300 minimum for a 1-1 ½ hour evaluation which may include standardized testing (as appropriate), clinical observations, and parent interview. This evaluation is intended to determine whether occupational therapy is appropriate for your child, as well as to assess foundational skills and deficits, and to provide a more comprehensive understanding of how to best address your child's needs. This option includes a written report and intervention plan (as applicable).

> *Note:* A current evaluation is required for ongoing therapy. An occupational therapy evaluation completed at another facility within the past 6 months is acceptable. If this option is chosen, first therapy session will be $150, which includes review of previous reports.

Consultation/Screening (without a report): $200 for the first hour, then at a rate of $150/hour. This service includes direct clinical observations of your child, followed by discussion of observations, recommendations, and specific home program activities, as appropriate. No formal written report is provided for this option. This method is not recommended for clients who will be receiving ongoing therapy, as most insurance companies require an evaluation for reimbursement.

Ongoing Individual Treatments and Consultations: $140 per 60-minute session. A current credit card on file or check deposit of $280 is required upon beginning ongoing therapy. This fee will be used as payment of the last two sessions prior to discontinuing therapy (see *Discontinuing Services* below).

Off-site Consultations: School, home, or community-based consultations will be provided at a rate of $140/hour plus a $25 flat rate to cover travel time and costs within a 30 mile radius of our clinic.

Written Goals/Intervention Plans and Progress Reports: Written goals/intervention plans and progress update reports are included for ongoing intervention every 6 to 12 months. Please let us know if your insurance plan has specific requirements in order to receive coverage. Additional written reports will be charged at a rate of $80/hour.

Phone Consultations: In order to best serve your child, we intend to keep open communication with families, and to collaborate with other caretakers and professionals involved in your child's life. There will be no extra charge for a phone consultation lasting up to 15-minutes. $80/hour will be charged for phone conferences lasting more than 15 minutes (pro-rated based on length of time).

Cash Rates:
Evaluation: $200 /1-1.5 hour evaluation
Treatment: $100/ 1 hour treatment session
Consultation: $150/hour for first hour $100/ hour following

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E-mail Communication: Our email is not secure, and should not be used for exchanging confidential information. Due to confidentiality, please do not use your child's name in e-mail. Instead, refer to your child with initials or using his or her treatment time and day. Cancellations must be made by phone if within 24 hours of scheduled session.

Payment

Payment is due at the time of service for cash clients and upon receipt of invoice for insurance clients. Payment options include credit, debit, check, or cash. Cash will also be accepted if exact change is given, as we do not keep cash readily available as change. If you choose to be a cash client, information will be provided to assist in receiving reimbursement, based on your individual policies. Please inform your therapist if any additional information is requested by your individual insurance policy. Charges are non-negotiable as agreed upon in service agreement. If payment is not made within three weeks of service date, your child will no longer receive services until the account is up to date.

Other fees

There is a $30.00 fee if your check is returned to our office unpaid by your financial institution.

Outstanding balances over 60 days are subject to collections, fees, and an interest rate charge of 18% APR.

Copies of pages from your child's chart are available to you for free up to 5 pages. Additional copies may be made at a rate of $0.50 per page.

Cancellations/Holidays

24-hour advance notice is required for cancellations.

- 24-hour cancellations, if in excess of 10 per year will be charged at $25.
- No-Shows will be charged at $50.

Please cancel your child's session if he/she has a fever, green mucous, or is otherwise known to be contagious. Although illness may happen suddenly, we ask that you contact us as promptly as possible if your child will miss his or her session.

Two consecutive no-shows may constitute termination of therapy, and the deposit will be applied or the credit card on file will be charged as payment for these two sessions.

Alysson Goodwin, OTR/L will be closed for most major holidays. Please speak with your therapist regarding specific dates.

At the end of your child's treatment session

Sessions are 50 minutes long with 10 minutes for transition, preparation, and documentation. Therapists have very tight schedules. If there are questions or comments that need to be discussed, the parent may request to have a shortened session with a private conference or set up an additional parent conference appointment. Therapists do not have the flexibility to have extended conversations without prior notice during a regular therapy day.

Attire

Clothing that is well fitted to the child's body, casual (active wear), and seasonable will be appropriate. Your child may be invited to participate in messy play.

Parent Policies

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Discontinuing Services

The decision to discontinue services should be a collaborative decision between the family and the therapist, and typically occurs once a child's needs are able to be met through an established home program and/or other services within the community. If you decide to discontinue services, or are unable to continue sessions at your child's current time, a 2-week notice to discontinue is required. If the family is unable to provide this notice, the deposit collected when your child began receiving services will be applied, or the credit card on file will be charged as payment toward the last 2 sessions.

Right to Refuse or Discontinue Services

Interpretation, recommendations, and treatment plans are based, in part, on the history and information that you provide Alysson Goodwin, OTR/L. If information about your child's medical/educational history, interventions, and needs are withheld, misrepresented, altered, or omitted, Alysson Goodwin, OTR/L. reserves the right to terminate the services. Services may be refused or discontinued due to non-payment of services, aggressive behavior, lack of progress, lack of cooperation, or a poor match between the needs of the family and skills of the therapist.

Waiting List

If we are unable to accommodate your child for intervention on a regular basis at a time that works for your family's schedule, you may opt to put your child on a waiting list for services. You will be notified by your preferred method of contact to answer any questions, and informational materials will be sent immediately about the clinic and services that we offer. We understand that a timely response is important. When your child is within the first 5 on the list, a caregiver questionnaire will be sent to the parents to start the evaluation process.

Families will be contacted in the order their request was received, and based on individual availability. Flexibility is important. If a time is available that you cannot accommodate, the next person on the list will be contacted. You will remain at the top of the list for the next available time. Regular updates on waiting list status will be emailed to those who request it. The waiting list will be no longer than 15 children; additional resources will be considered at this point to expedite the process.

Consent for Treatment and Billing Insurance

Alysson Goodwin, OTR/L

29 Race Street
Charleston, SC 29403
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Fax: (815) 346-2363
Alyssongoodwin@yahoo.com

CONSENT FOR TREATMENT
My signature below indicates that:

I have requested occupational therapy services for my child, _______________________________,
print child's name

Movement, moving equipment, as well as physical manipulation, are integral to our therapy interventions. While reasonable measures will be taken to avoid injury, I recognize that injuries can occur. Exposed skin and skin-to-skin contact may also occur with provision of services.

I confirm that I have received and reviewed the Parent Policies and Procedures and agree to adhere to the terms stated.

CONSENT TO BILL INSURANCE PLAN(S)
My signature below indicates that:

I give permission for Alysson Goodwin, OTR/L to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. Such necessary information may include my child's diagnosis, service dates, types of services and other information related to the provided services necessary to process claims.

I understand that if an insurance payment is made directly to the insured that was intended for Alysson Goodwin, OTR/L for services rendered, I am responsible for immediately sending such payments to Alysson Goodwin, OTR/L.

I will notify Alysson Goodwin, OTR/L of any changes to my child's health insurance coverage, as well as any denial information.

I understand that I am responsible for any balance that my insurance company does not authorize for payment.

_____________________________________ _____________________
Signature of Legal Guardian Date

_____________________________________ _____________________
Print name Relationship

Notice of Privacy Practices

Alysson Goodwin, OTR/L

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Alyssongoodwin@yahoo.com

Alysson Goodwin, OTR/L respects the confidentiality of its clients (child and legal parent/caregiver) and will maintain the privacy of your heath information by all applicable federal and state laws.
Information provided to Alysson Goodwin, OTR/L will be used or disclosed as follows:

Treatment: We may use and disclose your child's health information as part of assessment and intervention procedures. In addition, we may use and disclose your child's information with other caregivers, professionals, or persons working with your child, only when given written consent. If a parent/legal guardian would like Alysson Goodwin, OTR/L to consult with other caregivers/professionals/persons, he or she shall sign and submit a Release of Information form for that function.

Billing: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: Alysson Goodwin, OTR/L is a teaching facility. Your child's information may be used for the education of occupational therapy students and members of the community. Students, volunteers, and supplementary staff will sign a confidentiality agreement to adhere to the privacy policies and practices as outlined in this document. The quality of a child's therapy session is of primary importance. Students and volunteers will observe or participate only if this can be done without interfering with a child's session. For educational purposes your child's information may be used without consent, *only* with name and identifying information excluded. Occasionally persons within the community (for example, new parents or related services) may request to visit the facility. These visits will also be scheduled only if it is determined not to interfere with a child's therapy session.

Your Authorization:
You may give us written authorization (Release of Information) to use your child's information or disclose it to anyone for any purpose. If an authorization is provided to us for any individual or entity you may revoke the authorization in writing at any time.

To Your Family and Friends:
We must use and disclose your child's information to notify your family or any other person responsible for your child's care of your child's location, and/or general condition. If you are present we will provide you with the opportunity to object to such disclosures. Our Transportation Release form only grants permission for an individual to transport your child. If you would like for us to share information with those who may be transporting your child, we require a Release of Information for that individual. We will only provide information to individuals that have been identified on the Release of Information form.

Marketing
We will not use your child's information for marketing purposes without a written release.

Required by Law
We may be required to provide information to law officials under certain circumstances. We are mandatory reporters. We may be obligated to use or disclose your child's information if we believe that your child is a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes.

National Security
We may be obligated to use or disclose your child's information as required for national security: to military authorities or armed forces personnel, to authorized federal officials as required for lawful intelligence, counter-intelligence, and other national security activities, or to correctional institution or law enforcement official, having lawful custody of health information of inmate or patient under certain circumstances.

Appointment Reminders
We may use your child's information for appointment reminders (i.e. voice mail, reminder cards, post-it notes)
In order to ensure adherence to confidentiality policies, email communication will be limited to scheduling. When discussing your child via email, parent/legal guardian is requested not to use his/her child's name in the text (initials or treatment day/time would be acceptable).

We reserve the right to change our privacy practices at any time. If we change the privacy practices, we will issue a revised notice of privacy practices. If you wish to obtain an additional current copy of our privacy practices, you may obtain it at any time by contacting Alysson Goodwin, OTR/L. This Notice takes effect April 1, 2014, and will remain in effect until replaced.

Receipt of Privacy Practices

Alysson Goodwin, OTR/L

29 Race Street
Charleston, SC 29403
Phone: (843) 284-6278
Fax: (815) 346-2363
Alyssongoodwin@yahoo.com

I, ____, acknowledge that I have received and

Print Name of Legal Parent/Guardian

reviewed a copy of Alysson Goodwin, OTR/L's Notice of Privacy Policies and Practices.

I consent to Alysson Goodwin, OTR/L's disclosure of my child's information for treatment/intervention, billing, and healthcare operations according to the terms outlined in the Notice of Privacy Policies and Practices.

Signed,

____ _____________________________

Signature of Legal Parent/Guardian Date

____ _____________________________

Printed Name Date

==

For Office Use Only:

Reasonable attempts were made to obtain written acknowledgment of our Notice of Policies and Procedures. However, Alysson Goodwin, OTR/L was unable to obtain written consent due to the following:

- ☐ Individual Refused to Sign
- ☐ Communication barriers prohibited written exchange
- ☐ Other:

Explain:____

____

Additional Notes:

____

____