MPM Creative Therapy, LLC
1560 Hewatt Road SW
Lilburn, Ga 30047 469-431-3830
information@mpmctherapy.com

Patient Information/Consent Form

Patient Name: _____

DOB: _____ Gender: male female

Address: _____

Parent/Guardian 1: _____

DOB: _____ SS#: _____

Cell #: _____ Home#: _____ Work #: _____

Employer: _____

Email 1: _____ Email 2:_____

Parent/Guardian 2: _____

DOB: _____ SS#: _____

Cell #: _____ Home #: _____ Work #: _____

Employer: _____

Email 1: _____ Email 2: _____

Primary Care Physician

Name of Practice or Doctor: _____

Phone #: _____ Fax #: _____

Address: _____

Diagnosis or reason for referral: _____

Primary Insurance Company: _____

Patient Name: _____ DOB: _____

Insured's Name: _____ relationship: _____ DOB: _____

Customer Service/Provider #: _____

Claims Address: _____

Member/Subscriber ID #: _____ Group /Account #: _____

Secondary Insurance Company: _____

Patient Name: _____ DOB: _____

Insured's Name: _____ relationship: _____ DOB: _____

Customer Service #: _____

Claims Address: _____

Member ID #: _____ Group/Account #: _____

___I DO NOT HAVE INSURANCE, OR I DO NOT WISH TO BILL MY INSURANCE FOR SERVICES RENDERED. I UNDERSTAND THAT MPM CREATIVE THERAPY REQUIRES THAT ALL PAYMENTS FOR SERVICES RENDERED BE PAID IN FULL AT THE TIME OF SERVICE. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY MPM CREATIVE THERAPY OF ANY CHANGES. I HEREBY CONSENT THAT ALL INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

X_____ **X**_____ _____

Parent/Guardian (print name) Parent/Guardian signature Date

It is important for authorization and billing purposes that you provide MPM Creative Therapy Services with as much information about the services your child has received or is currently receiving. This does not mean that you will not receive services with MPM Creative Therapy Services.

Does your child receive Speech-Language, Occupational or Physical Therapy services within the Public-School System? _____
If yes, what county? _____ Frequency _____

To ensure accurate services are provided and that your child receives the best care, MPM Creative Therapy Services. We MUST have a copy of your child's current IEP before providing services.

Most insurance companies require pre-certification or authorization to be in place prior to services being rendered. If there is another authorization in place with a different provider your insurance company will not approve services with MPM Creative Therapy Services. Therefore, you will be responsible for any charges denied by your insurance company for this reason.

Other than the school system; is your child receiving Speech-Language, Occupational or Physical Therapy services with another company? _____ If yes, please explain _____
Place initials in the blank:

_____ As a courtesy, MPMC Therapy will verify your benefits with your insurance company. However, the verification of benefits is not a guarantee of payment. Claims payment is determined at the time services are rendered, eligibility at

the time of service and exclusions or provisions on your plan. It is also recommended that you call your insurance company to verify your benefits.

_____ Please remember that each Medicaid program has different authorization requirements. It is very important that you notify our office of any changes. This will ensure that your child receives continuation of care and that we obtain authorizations as required by your policy.

_____ The insured/parent/guardian listed above is fully responsible for any balance due, non-covered services, and/or denied claims for any reason.

_____ I authorize MPMC Therapy to release any medical records or other information necessary to process claims pertaining to my treatment.

_____ I authorize payment of medical benefits to MPMC Therapy Services. I also understand that it is my responsibility to inform this office of any insurance or address changes.

_____ I have been notified of all HIPAA regulations and I have received and read a copy of the Privacy Practice regulations implemented by MPMC Therapy.

_____ I understand that I am making a commitment based on the recommendations made by my clinician for my child. It is my responsibility to make sure that my child is at each scheduled appointment, report any changes in address or insurance coverage and to implement the home program provided by my child's clinician.

_____ I understand that session begins when clinician arrives at the treatment address on file.

I hereby consent that all information provided on this form is true to the best of my knowledge. I also understand that services will be provided as recommended by my physician and the Speech-Language Pathologist.

X_____	**X**_____	_____
Parent/Guardian (print name)	Parent/Guardian signature	Date

CANCELLATION POLICY:

Your child's progress in therapy is contingent upon consistency with your weekly scheduled appointments and the home program implemented by your therapist. MPM Creative Therapy Services is committed to providing quality services to your family but it is the sole responsibility of the parent/guardian to reschedule any missed or cancelled appointments. After 3 no show appointments and/or cancellations with less than a 2-hour notice will result in termination of services.

We do understand that sometimes circumstances present themselves and therefore will be considered on a case-by-case basis. Please call our office at 678-467-7732 should you need to cancel or reschedule your appointment.

There will be a $25 charge for all no call/no show appointments or calling less than 2 hours before your scheduled appointment. This will still count as one of your three cancellations.

X _____ _____

Signature **Date**

_____ _____

Patient Name Relationship to patient

Authorization to use or disclose Protected Health Information

Patient Name: _____ DOB: _____

Address: _____

Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practice without your authorization.

I hereby authorize _____ to use or disclose my Protected Health Information to the following person(s), entity(s), or business associates of this office: _____

Name of business: _____

Address: _____ Phone #: _____ Fax #: _____

Patient Health Information authorized to be disclosed and why:

_____

_____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____. This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending a written note to this office and that revocation will not affect this offices' previous release on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Protected Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reason beyond our control. I also understand that if I do not sign this document it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

X_____ _____

Signature of patient or patients authorized representative **Date**

Relationship to patient: _____

X_____ _____

Authorized signature of facility Date

Background Information

Patient Name: _____ Parent/Guardian: _____

DOB: _____ Gender: Male / Female Home Phone: _____

PCP (referring physician): _____

Other physicians and specialist who provide care to the patient: (list others on back of page)

Name _____ Specialty _____

Name _____ Specialty _____

Patient lives with (check one): ☐ Birth Parents ☐ Adoptive Parents ☐ Foster Parents ☐ One Parent ☐ One Parent and Step-Parent ☐ Other _____

Any language other than English spoken at home? ☐ Yes ☐ No If yes, what? _____ Does the patient speak the language? ☐ Yes ☐ No Does the patient understand the language? ☐ Yes ☐ No Please list the name, age and relation of those (other than parents) living in the patient's home.

Name	Age	Relationship

Does your child currently have a diagnosis? ☐ Yes ☐ No
If yes, what is it? _____
Does your child attend a school or daycare? ☐ Yes ☐ No
If yes, where and current grade level? _____
Does your child have an Individualized Education Plan (IEP)? ☐ Yes ☐ No
If yes, what special services is your child receiving (speech, OT, PT, etc.)? _____ If yes, we will need a copy of the patient's most current IEP. Birth History Pregnancy: ☐ Full Term ☐ Premature (_____ weeks) Birth Weight: _____

Illnesses or accidents during pregnancy? _____

Use of alcohol, tobacco, or medications during pregnancy? _____

Delivery: ☐ Vaginal ☐ C-section ☐ Breech ☐ Feet First ☐ Forceps/Suction Required

Other unusual conditions that may have affected pregnancy or birth? _____

_____

Did your child pass the infant hearing screening? ☐ Yes ☐ No

Medical History

Has your child had any of the following? ☐ Adenoidectomy ☐ Ear Tubes ☐ Sleeping Difficulties ☐ Allergies ☐ Encephalitis ☐ Surgery (specify below) ☐ Breathing difficulties ☐ Head Injury ☐ Thumb/finger sucking ☐ Breaths from mouth only ☐ Hearing Problems ☐ Tonsillectomy ☐ Colds ☐ High Fevers ☐ Tonsillitis ☐ Ear Infections ☐ Meningitis ☐ Vision Problems How often? ☐ Seizures

Are immunizations current? ☐ Yes ☐ No

Is your child currently under a physician's care? ☐ Yes ☐ No If yes, why? _____

Please list any medications your child takes regularly: _____

Does your child have any food or medical allergies? ☐ Yes ☐ No If yes, explain:

_____

Has your child or do they currently receive any therapy services (OT, PT, ABA, etc.)? _____

Type of Therapy, Frequency of Visits, Dates of Services, Location, and Treating Clinician: _____

_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

crawled _____ sat up (no assistance) _____ stood alone _____ walked _____ drink open cup _____

drink with straw _____ fed self (fingers) _____ fed self (spoon/fork) _____Dressed ____ self-toilet trained _____

single words _____ combined words_____

Does your child show unusual behavior (explain)? _____ Does

your child… (Check all that apply)

☐ Not eat enough variety ☐ Only eat crunchy solids ☐ Vomit during/after meals ☐ Poor growth/weight gain ☐ Aspiration (choking) ☐ Only eats purees ☐ Gagging ☐ Frequent diarrhea ☐ Only drink fluids ☐ Avoids whole food groups ☐ Frequent constipation ☐ Transitioning from tube to oral feeding ☐ Tooth brushing intolerance

☐ Not eating enough volume ☐ Food refusal

Favorite Foods: _____

Aversion Foods (if any): _____

Language Development

In which of the following areas does your child seem to have trouble? Check all that apply.

☐ Hearing Sounds ☐ Learning and using new words ☐ Stuttering ☐ Understanding what others say ☐ Using sentences

☐ Reading/writing ☐ Saying speech sounds ☐ Voice difficulties ☐ other (please describe)

_____

How many words are in your child's expressive vocabulary? ☐ 0-5 ☐ 10-20 ☐ 25-50 ☐ 50+

Is your child difficult to understand (check all that applies)? ☐ to you ☐ to family members ☐to unfamiliar listeners

Sensory Processing

The following questions are designed to help gives us a more complete picture of your child.

Does your child:

Like to be touched?

Have a strong need to touch/ hold people or objects?

Seem easily irritated or enraged when touched by others?

Pinch, bite or otherwise hurt self or others?

Mouth objects or clothes excessively?

Does child have ☐ Hypersensitivity to sounds? ☐ Fear of unexpected noises?

Is your child: ☐ Easy going, predictable ☐ Rigid, set in ways ☐ Adaptable, flexible ☐ Able to play alone

☐ Become frustrated easily? ☐ Have short attention span? ☐Become easily distracted? ☐Struggle with making choices? ☐Have self-stimulation behaviors? ☐Act out?

What do you hope to gain from therapy at MPM Creative Therapy Services?

_____

_____

X_____ _____

Parent/Guardian Signature **Date**

Consent for Disclosure

I give MPM Creative Therapy Services my consent to use or disclose my protected health information or PHI to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review MPM Creative Therapy Services Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that MPM Creative Therapy Services has the right to change their Privacy Practices and that I may obtain any revised notices at MPM Creative Therapy Services.

I understand that I have the right for request a restriction of how my Protected Health Information is used. However, I also understand that MPM Creative Therapy Services is not required to agree to the request. If MPM Creative Therapy Services agrees to my requested restrictions they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

X_____ _____ **Signature of**

patient, parent or legal guardian **Date**

_____

If signed by someone other than patient, state relationship to the patient

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. MPM Creative Therapy Services is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with MPM Creative Therapy Services." "It is our policy to provide a substitute health care provider, authorized by MPM Creative Therapy Services to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to MPM Creative Therapy Services, for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health, as required by law: We may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: If may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious an imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing: We may contact you for marketing purposes or fundraising purposes, as described below (example) "No personal health information will be disclosed during a recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment." "It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation is such event. It is not our policy to disclose any personal health information about your condition for the purpose of MPM Creative Therapy Services sponsored fund-raising events."

Change of Ownership: In the event that MPM Creative Therapy Services is sold or merged with another organization, your health information/records will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that MPM Creative Therapy Services is not required to agree to the restriction that you have requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that MPM Creative Therapy Services amend your protected health information. Please be advised, however, that MPM Creative Therapy Services is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by MPM Creative Therapy Services
- You have a right to a paper copy of the Notice of Privacy Practices at any time upon request.

Change to this Notice of Privacy Practices: MPM Creative Therapy Services reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, MPM Creative Therapy Services is required by law to comply with this Notice.

MPM Creative Therapy Services is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact me.

Complaints

Complaints about your Privacy rights or how MPM Creative Therapy Services has handled your health information should be directed to MPM Creative Therapy Services if you are not satisfied with how your complaint was handled, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W. Room 509F HHH Building
Washington, DC 20201