Believe
Pediatric Physical Therapy, LLC
Dayna Brunette Physical Therapist, Inc. *and* Trevor MacLaren Physical Therapist, Inc.
5506 Lake Howell Road, Winter Park, FL 32792 ● Phone 407-679-7837; Fax 407-679-7840 ● www.believetherapy.com

Patient Intake Form

Patient Name: _____ Date of Birth: _____
Patient Height:_____Weight:_____
Address: _____
_____
Phone Number: _____
Mother's Name: _____ Cell / Work Number: _____
Father's Name: _____ Cell / Work Number: _____
Email Address:_____

Brief Medical History
Patient Diagnosis:_____
Referring Physician:_____
Referring Physician Contact Number:_____
List of Medications patient is taking:_____
_____
Any known allergies?:_____
Born at how many weeks gestation?_____
Any complications with pregnancy? YES / NO
If yes, please explain:_____
_____
_____
_____
Please explain complications that occurred during birth:
_____
_____
_____
_____
_____
Please list any previous surgeries and dates:_____
_____
_____
Does your child have seizures?_____ Date of last seizure:_____
Are seizures controlled with medications? _____
How frequently do seizures occur? _____
Does your child have a shunt?_____

Does your child have any cardiac conditions?_____
If yes, please describe_____
Does your child have high blood pressure?_____
Does your child have a G-tube?_____
Has your child had a hip and spine x-ray within the last 6 months? YES/NO
Has your child ever had a hip dislocation , subluxation, or fracture? YES/NO
If so, which hip and degree of subluxation?:_____
Date of occurrence:_____ Was it repaired?_____
Does your child have a bone condition or brittle bone disease?_____
Does your child have scoliosis?_____ Type & Degree of curvature:_____
Does your child have respiratory conditions?_____
Does your child have diabetes?_____
Does your child have any behavioral or social concerns?_____
Please explain results of last hearing and vision test:_____
Does your child appear to be sensitive to sensory input including from sounds, touch, movement, light, pain, temperature, clothing?: If yes, please explain _____
_____
Please explain how your child communicates wants and needs to you (words, sounds, gestures, sign language) :_____
_____
Please list any other conditions not mentioned above in which precautions need to be taken (Please list even if you are not sure):
_____
_____
_____
Please indicate what developmental milestones your child has achieved. Check all that apply:
_____ Attained head control
_____ Rolling
_____ Belly Crawling
_____ Creeping on hands and knees
_____ Sitting
_____ Standing
_____ Walking

Please explain your primary concerns / difficulties for your child:
_____
_____
_____
_____
_____

Please describe how these concerns / difficulties have or have not improved:_____
_____
_____
Please list what areas you would like to be addressed in therapy:_____
_____
_____
Please list your goals for your child:_____
_____
_____
Please list activities that your child enjoys:_____
_____
_____
Please list the name of your child's school, grade, and program:_____
_____
Please list current physical, occupational, or speech services your child is receiving at another facility or at school (Be sure to include frequency and duration for each discipline):
_____
_____
_____
Additional Comments / Concerns:_____
_____
_____

Emergency Contact

In the event of an emergency, please list contact information:

1. Name: _____ Phone:_____
2. Name: _____ Phone:_____

Emergency Medical Release:

In the event that my child needs emergency medical care due to an accident or illness while receiving therapy services at this practice location of Believe Pediatric Physical Therapy, LLC I grant permission to call 911 and / or perform routine medical care including CPR and First Aid. If I am absent from my child's therapy session, and / or if I cannot be reached, above is the listed emergency contacts to be called immediately.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

Parent / Guardian Signature:_____ Date_____

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Consent for Treatment/ Informed Consent Waiver

I _____ (Print Parent / Guardian Name) allow Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc., and Trevor MacLaren Physical Therapist, Inc. to provide physical therapy services to my child _____(Child's Name) in the form of either traditional physical therapy services or intensive therapy program.

If participating in an intensive therapy program, I understand that the intensive therapy program provided by Believe, LLC involves 4 hours of therapy services per day, 5 times a week, for 3 weeks. I have discussed the prescribed treatments with my child's physician and understand the benefits and risks associated with this treatment and choose to participate in this program. I also understand that a child's progress in the intensive therapy program may vary from child to child and is dependent upon a number of factors. I understand that traditional physical therapy services provided by Dayna Brunette Physical Therapist, Inc. and Trevor MacLaren Physical Therapist, Inc. may also include the use of the Universal Exercise Unit, Therasuit, and all other therapeutic or specialized equipment at the practice location of Believe, LLC for physical therapy services.

By signing this consent for treatment/ informed consent waiver, I hereby release Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc., and Trevor MacLaren Physical Therapist, Inc. from any liability, claims, and causes of action, now or in the future, resulting from injury however caused, whether occurring during or after participation in the 3-week intensive therapy program or traditional physical therapy services. I also affirm that I have read the above statements, understand the inherent risks involved, and give permission for my child to participate in physical therapy services with Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc., and Trevor MacLaren Physical Therapist, Inc.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL. This document will be enforced for the time span of one year after the date written by the signee.

_____ _____

Printed Name of Parent / Guardian Date

_____ _____

Signature of Parent / Guardian

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We must provide this notice to you no later than the date of the first service delivery including service delivered electronically to you.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information

We use health information about the client for treatment, to obtain payment for treatment, for health care operations, and to assess the quality of health care that you receive. Information may be shared by paper, mail, electronic mail, fax, or other methods and may be used by office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your treatment. We may disclose your health information to other health care professionals who are involved in your care. For example, a doctor or healthcare facility involved in your care may request personal health information to enable them to provide care.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, we may use your personal health information to collect payment from a third party and /or request authorization for services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to operate our health care practice. For example, we may use your health information to evaluate our treatment services to maintain a high quality of care, inform you of other services available, provide you with reminders, or provide general information as needed.

Other Health Care Related Uses: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer.

We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. We must present to you our Notice of Privacy Practices as soon as it is reasonably practicable after the delivery of treatment.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We are permitted or required by law to use or to disclose personal health information, without your authorization in the following circumstances.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

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

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes as otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs or has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Client's Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information that we may use to make health care related decisions about you. If you have any questions about your protected health information and / or believe that information is incorrect or missing, you have the right to request that we correct the existing information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be written and state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to amend your protected health information. This means you may request an amendment of protected health information to correct inaccuracies.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

If you are concerned that we have violated your privacy rights, you may complain to us or to the Department of Health and Human Services. You may file a complaint with us by notifying our privacy contact of your complaint. All complaints must be submitted in writing.

You may contact our Privacy Contacts, **Dayna Brunette, MS,PT or Trevor MacLaren, MS,PT, C/NDT** at **407-679-7837** or **office@believetherapy.com** for further information or concerns and we will be happy to respond. Please submit your compliant in writing to: **Believe Pediatric Physical Therapy, LLC**
5506 Lake Howell Road
Winter Park, FL 32792

Effective Date: This notice is effective January 13, 2014.

By signing this form you have read and understand this Notice of Privacy Practices and agree to let Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc. and Trevor MacLaren Physical Therapist, Inc. utilize your health information for purposes of treatment, payment, and all / or any health care operations.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL. This document will be enforced for the time span of one year after the date written by the signee.

Child's Name: _____

Name of Parent / Guardian:_____ Date:_____

Signature of Parent / Guardian:_____

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Insurance Intake Form for Traditional Therapy

If your child has Medicaid or CMS, please fill in the following information:

Patient Name:_____ □Medicaid □CMS Title IX □CMS Title XXI

DOB:_____ Recipient ID#:_____

Address currently on file with Medicaid:_____

_____

Primary Care Provider:_____

Doctor Phone:_____Doctor Fax:_____

Doctor Address:_____

I verify that the information I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies and their agencies, for the purpose of filing and payment of medical claims. I also authorize payment of the medical benefits to the provider. I agree and acknowledge that I am responsible for all deductibles, co-pays, and non-covered services. I am aware that a fee at the provider's current rate may be charged on all past due balances.

Signature of insured or authorized person	**Date**

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Patient Assignment of Benefits

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all the medical services, which are provided by Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc., and Trevor MacLaren Physical Therapist, Inc. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. The intensive therapy program provided by Believe, LLC is not a program that is covered by insurance companies, and we do not accept payment from insurance companies for this program. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the members of Believe, LLC, Dayna Brunette Physical Therapist, Inc. and Trevor MacLaren Physical Therapist, Inc. the following rights, power, and authority:

CONSENT FOR TREATMENT: The undersigned hereby consents to the provision of examination, evaluation, treatments, and therapies, supplied to the patient as ordered by the patient's health care provider of Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc. and Trevor MacLaren Physical Therapist, Inc. and acknowledges that no guarantee or assurance has been made to the results of such treatment. The undersigned hereby also acknowledges the inherent risks associated with physical therapy treatment.

ASSIGNMENT OF RIGHTS: I am assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of my bill for total services, including exclusive, irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, courts costs, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and any information supporting documentation concerning or touching upon handling, calculation, procession, or payments of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind for treatment rendered by Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc. and Trevor MacLaren Physical Therapist, Inc. I am hereby tendered demand to pay in full the bill for services rendered by these companies, and it is to the client's own discretion to attempt to attain reimbursement from their insurance company for services provided. Believe, LLC will not accept payment from insurance companies for this intensive therapy program.

STATUTE OF LIMITATION: I waive the right to claim any Statute of Limitation regarding claims for services rendered or to be rendered by the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of the Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL. This document will be enforced for the time span of one year after the date written by the signee.

Signature of Patient and/or Responsible Party:

Sign here_____ Date_____

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Payment Policy

_____**OUT OF NETWORK INSURANCE:** All clients that are NOT insured with a plan that Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc., and Trevor MacLaren Physical Therapist, Inc. participates with are required to pay for therapy services in full at the time of service.

_____**CO-PAYMENTS AND DEDUCTIBLES:** All clients are responsible to pay co-payments and deductibles at the time of service, as part of your contract with your insurance company. Please contact your insurance company if you have any questions regarding your coverage

_____**CLAIMS SUBMISSION:** All clients are responsible to comply with their insurance companies requests. It is the client's responsibility to pay the remaining balance of the claims whether or not the insurance company pays for the claim.

_____**NON-COVERED SERVICES:** All plans and insurance coverage varies for each client. Some or all services that a patient receives may or may not be covered, nor do some insurance companies consider some services to be reasonable or necessary. It is the client's responsibility to pay for these services in FULL at the time of service.

_____**NON-PAYMENT:** Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc, and Trevor MacLaren Physical Therapist, Inc does not accept partial payment for services. Each client is responsible to pay their balance in FULL at the time of service. If your account has not been paid in full, you will receive a statement that allows for 10 business days to pay the account in full. If the account remains delinquent after this time, or there are a repeated number of times where payment is not received on time, Believe, LLC, Dayna Brunette Physical Therapist, Inc., and Trevor MacLaren Physical Therapist, Inc. reserves the right to discharge clients for non-payment of services and interest charges will accrue.

_____**COVERAGE CHANGES:** It is the responsibility of the client to provide Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc, and Trevor MacLaren Physical Therapist, Inc. with the appropriate changes to your insurance plans prior to the next visit to ensure that you can receive maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

_____**MISSED APPOINTMENTS:** All clients will be charged $25.00 for missed appointments not cancelled within **24 hours** of your appointment time. These charges will be the clients responsibility to pay in FULL and will be due prior to or on the next scheduled visit. Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc, and Trevor MacLaren Physical Therapist, Inc. reserves the right to decrease treatment frequency or discharge any client who consistently has more than 3 absences per month, and / or consistently arrives more than 15 minutes late. Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc, and Trevor MacLaren Physical Therapist, Inc. reserves the right to discharge any patient that has 3 NO SHOWS to their therapy appointments.

_____**STATUTE OF LIMITATION:** I waive the right to claim any Statute of Limitation regarding claims for services rendered or to be rendered by Believe Pediatric Physical Therapy, LLC, Dayna Brunette Physical Therapist, Inc, and Trevor MacLaren Physical Therapist, Inc. In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of the Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

I have read and initialed each section of the payment policy, and agree to abide by these terms.

Signature of Insured Person:

Sign here_____ Date_____

Print Name: _____

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Photo Release

Believe Pediatric Physical Therapy, LLC. maintains a website and printed brochures, and information packets that include photographs of our facility, equipment, therapists, families, and patients that participate in physical therapy services. We intend to use these photographs for promotional, informational, and educational materials. To enable us to include your child / family in our website or printed materials we require your written consent.

I _____ (print name), am the parent / guardian of _____ (print child's name) and grant full permission to Believe Pediatric Physical Therapy, LLC employees, staff, volunteers, or any party they designate, to use photographs and / or written information of my child in the Believe Pediatric Physical Therapy, LLC website or printed materials. I waive my right to inspect and approve the finished product or copy that may be used.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

_____ _____
Printed Name of Parent / Guardian Date

_____ _____
Signature of Parent / Guardian Date

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Payment and Cancellation Policy

Deposits for Intensive Therapy Session
The total amount for a 3 week session is $7,200 USD prior to January 2020, and $7800 beginning January 1, 2020. A $2,000 deposit is required to reserve a space in a session. Placement will not be reserved until deposit payment is received. The remaining balance is due four weeks prior to the beginning of the session. If the remaining balance is not paid in full prior to the session, the deposit will be credited toward any available session within the next 12 months.
Please note: *The deposit is non-refundable and expires one calendar year after receipt*

Payment for Traditional Therapy Services
Physical therapy services are $120 USD per hour. Private pay, Medicaid and CMS are accepted for traditional therapy services only.

Payment Policy
We accept personal check, money order, and Visa and MasterCard. If paying by check, payer will be held responsible for any bank costs and / or fees incurred from insufficient funds and / or any returned checks, above and beyond the total cost of the session.

Insurance Policy
We do not bill private insurance for the intensive therapy program. Many patients have had success for reimbursement from their insurance company for some portion of the program. We are happy to provide any information and therapy codes upon request for your convenience.

Cancellations for the Session
After deposit or full payment has been made, a full refund will be made within 90 days for the following reasons:

1. Child does not meet the criteria to participate in our intensive program.
2. The physician will not authorize participation in the program due to medical reasons.

Proper documentation will be required in order to process the refund.
Cancellations for the session for any reason other than those listed above will result in the deposit or full payment being applied to another available session within one calendar year. These funds are non-refundable and will expire after one calendar year.

Cancellations for Sick Days
Due to the nature of the intensive therapy program, refunds or credits will not be given for days missed during a session as a result of the patient becoming sick during a session. If there is space available in the subsequent session, missed treatments may be rescheduled, but this is not guaranteed and is based on availability. A personal day or leaving early from therapy is not a reason for the therapists to provide makeup days.

Cancellations for Hurricane/Severe Weather
Therapy will be cancelled for severe weather if local schools are cancelled. If one to three days are missed during the session due to severe weather, then we will do our best to make up those days, however makeup days will not be guaranteed due to time restrictions and succeeding sessions. A refund will not be given for any one of those days missed. If our clinic is open, but a parent chooses not to attend due to rain or other weather conditions, make-up days or a refund will not be issued. If your child misses more than 3 days due to severe weather conditions and we are unable to offer make-up days, then a credit will be provided to the child towards another session within one calendar year.

I hereby understand this policy and agree to the terms stated.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

_____ _____
Printed Name of Parent / Guardian Date

_____ _____
Signature of Parent / Guardian

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Sickness Policy

Many of our patients have increased susceptibility to any illness, however minor, we ask that all parents be conscientious when their child is not feeling well. Your child will benefit from therapy more if they are feeling well, so it is best to give them time to recover when they are ill. Please DO NOT bring your child to therapy if they have the following:

- Any fever (99 and above)
- Green or yellow runny nose
- Vomiting or diarrhea due to illness
- Any change in skin color or texture
- Breathing difficulty
- Coughing fits/ coughing up mucous
- Any infectious illness such as a rash, impetigo, pink eye, chicken pox, etc.
- Ring worm
- Other

If your child becomes ill during treatment, we will discuss this with the parent/guardian and therapy will be on hold until your child recovers. If there is an emergency situation, we will call 911 and we will contact the parent/guardian if they are not present.

If the child comes to therapy with any infectious illness, it is up to the clinician's discretion to cancel the treatment.

I understand this policy for the interest of all the children participating in physical therapy services and for the interest of the treating therapists.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

_____ _____
Printed Name of Parent / Guardian Date

_____ _____
Signature of Parent / Guardian Date

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EMAIL USE CONSENT FORM

1. <u>RISK OF USING E-MAIL</u>
Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Believe Pediatric Physical Therapy (the Practice) are minimally encrypted and are HIPAA-compliant, but E-mails may not be completely secure. Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail senders can easily misaddress an E-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
i) Practice server could go down and E-mail would not be received until the server is back on-line.
j) E-mail can be used as evidence in court.

2. <u>CONDITIONS FOR THE USE OF E-MAIL</u> Practice cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Practitioners are not liable for improper disclosure of confidential information that is not caused by Practice's or Practitioner's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. Practice and Practitioner cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.
b) If the patient's E-mail requires or invites a response from Practice or Practitioner, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.
c) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
d) All E-mail will usually be filed in the patient's medical record.
e) Office staff may receive and read your messages.
f) Practice will not forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.

h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by E-mail with Practice.

3. INSTRUCTIONS

To communicate by E-mail, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Practice of changes in his/her E-mail address.
e) Acknowledge any E-mail received from the Practice and/or Practitioner.
f) Take precautions to preserve the confidentiality of E-mail.
g) Protect his/her password or other means of access to E-mail.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge Believe Pediatric Physical Therapy LLC, Trevor MacLaren Physical Therapist Inc. and Dayna Brunette Physical Therapist Inc. and their affiliates, officers, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

Patient Name:_____

Parent Signature:_____

Date: _____