Dear Prospective Parents, Guardians, and Clients:

Welcome to Hearts and Hands Therapy Services! Enclosed is the initial registration paperwork necessary to begin therapy with us. Please fill out the forms **completely** and be sure to note any and all diagnosis and reasons for evaluation and therapy. In addition to the enclosed documents, please provide the following:

- Copy of current Insurance card(s) front and back
- Copy of your child's school IEP or IFSP (if they have one)
- Copy of the prescription from your child's physician for the "Evaluation and Treatment" of whichever therapy you are requesting. *(If you do not have this at the time the forms are being completed please make sure your physician faxes a prescription to the fax number below.)*
- Please note that several insurance companies (including Peach State, CareSource, and Amerigroup) also require a copy of a hearing test documenting results at each Hertz level for speech therapy.

You can return the completed forms and documents in any of the following ways:

1) Fax to 1-844-471-3799
2) Email to info@hhtsclinics.com
3) Mail to our central administrative office:

Hearts and Hands Therapy Services, Inc.
Attn: Patient Intake
2001 Professional Pkwy, Ste 220
Woodstock, GA 30188

Once **all** information is received you will be placed on a priority list for scheduling and will receive a call within 5 business days upon receipt of all documents. If you have any questions, please call our office at 1-844-543-8437 at any time during the registration and placement process.

Thank you for choosing Hearts and Hands Therapy Services! We look forward to working with your family.

Child's Information

Child's Name: _____ Date of Birth: _____Age: ____

Current Address: _____

City: _____ State: _____ Zip code: _____

Gender: ❑ Male ❑ Female

Parent / Guardian Contact Information:

❑ Mother ❑ Father ❑ Guardian: Name: _____

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

Email: _____

Address: ❑ Same as child

Street: _____

_____

City: _____ State: _____ Zip: _____

❑ Mother ❑ Father ❑ Guardian: Name: _____

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

Email: _____

Address: ❑ Same as child

Street: _____

_____

City: _____ State: _____ Zip: _____

Emergency Contact Information

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Services

Child's Name: _____

Office Location Requested:

❑ Teletherapy

Services Requested:

❑ Occupational Therapy

❑ Speech Therapy

❑ Physical Therapy

❑ ABA (behavioral) Therapy

❑ Feeding

Diagnosis (*Please list all*):

Is your child currently receiving other therapy services in school or privately? ❑ Yes ❑ No

(If Yes, Please List)

Does your child have an IEP or IFSP? ❑ Yes ❑ No (*If yes, we **must** have a current copy)*

What school does the child attend?: _____

Grade/Type of Classroom: _____

Physician Information (* = required information, if applicable)

(Your child's pediatrician who will sign all necessary documents for ongoing therapy)

*Doctor's Name: _____

*Phone Number: _____

*Fax Number: _____

*Clinic or Doctor's Group Name: _____

*Address: _____

*City: _____ *State: _____ *Zip code: _____

Insurance Information

Child's Name: _____ Date of Birth: _____

Are you requesting services as a result of an accident, injury, or illness: ❑ Yes ❑ No

If yes, date of accident/injury/illness: _____

Primary Insurance Information (* = required information, if applicable)

PLEASE ATTACH COPY OF CARD (FRONT AND BACK)

*Primary Insurance: _____ *Phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

*Member #: _____ *Group #: _____

*Guarantor Name: _____ *Date of Birth: _____

*Guarantor Social Security #: _____ *Relationship to patient: _____

*Co-Pay: _____

Secondary Insurance Information (* = required information, if applicable)

PLEASE ATTACH COPY OF CARD (FRONT AND BACK)

* Secondary Insurance : _____ *Phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

*Member #: _____ *Group #: _____

*Guarantor Name: _____ *Date of Birth: _____

*Guarantor Social Security #: _____ *Relationship to patient: _____

*Co-Pay: _____

MEDICAID (* = required information, if applicable)

PLEASE ATTACH COPY OF CARD (FRONT AND BACK)

*Medicaid ID#: _____

Child's Case History

General Information

Child's Name: _____ Today's Date: _____

Has your child in the past or does your child currently receive any of the following special services?

Service Currently Received	Provider / Reason for Service
❑ Occupational Therapy	_____
❑ Speech Therapy	_____
❑ Physical Therapy	_____
❑ ABA (behavioral) Therapy	_____

Other Children in the Family:

Name: _____ Age: ___

Name: _____ Age: ___

Name: _____ Age: ___

Name: _____ Age: ___

Language Issues / Assistive Equipment / Existing Plans

Describe any family history of speech, hearing or language delays/difficulties:

Is there a language other than English spoken in the home? ❑ Yes ❑ No

If yes, which one? _____

Does the child speak the language? ❑ Yes ❑ No

Does the child understand the language? ❑ Yes ❑ No

Who speaks the language? _____

Does your child wear/use any assistive devices ❑ Yes ❑ No

(i.e. hearing aids, splints, orthotic inserts, augmentative communication device, protective head gear?) If yes, Please Explain: _____

Does your child have an IEP or an IFSP? ❑ Yes ❑ No

For example, from the school system or Babies Can't Wait. If so, what services does he/she receive?

Birth History

Were there any difficulties during pregnancy or birth? ❑ Yes ❑ No

If yes, please describe:

What was mother's age when the child was born? ____

How many months was the pregnancy? ____

How much did the child weigh at birth? ____

Were there any feeding or breathing problems at birth? ❑ Yes ❑ No

Medical History

Has your child had any of the following?

❑ ear infections	❑ adenoidectomy	❑ allergies
❑ ear tubes	❑ tonsillectomy	❑ colds
❑ hearing problems	❑ breathing problems	❑ strep throat
❑ seizures	❑ sleeping problems	❑ tonsillitis
❑ head injury	❑ whooping cough	❑ vision problems

Other serious injury/surgery:

_____

Is your child currently (or recently) under a specialist's (e.g neuro, GI, etc) care? ☐ Yes ☐ No

If yes, why?_____

Please list any medications your child takes regularly including emergency medication and dosages:

Any Food allergies? ☐ Yes ☐ No

If Yes, Please list: _____

Has your child ever had a seizure? ☐ Yes ☐ No

Does your child have a seizure plan? ☐ Yes ☐ No

If yes to either question, our staff will send you a seizure plan to complete and have on file.

Developmental History

Please list the age your child met these developmental milestones:

Milestone	Age	Milestone	Age
Rolled over	_____	Sat unsupported	_____
Crawled on hands and knees	_____	Stood alone	_____
Walked alone	_____	Toilet trained	_____
Finger fed self	_____	Used utensils	_____

How long did your child crawl on hands and knees? _____

Feeding History

Has your child in the past or does your child currently receive feeding/swallowing therapy?

☐ Yes ☐ No

Does your child have feeding/swallowing problems (ex: gagging, choking, coughing, not chewing, etc.) ☐ Yes ☐ No

If yes, please describe: _____

Did your child have difficulty with breast of bottle feeding? ☐ Yes ☐ No

Did your child have difficulty transitioning to solid foods? ☐ Yes ☐ No

Is your child a picky eater?

If yes, please explain: _____

Speech Hearing and Language

At what age did your child:

Milestone	Age	Milestone	Age
Babble	____	Put two words together	____
Use first words	____	Talk in short sentences	____

Does your child use word to make his/her needs known? ☐ Yes ☐ No

Does your child use gestures or pointing to make his/her needs known? ☐ Yes ☐ No

Does your child understand what you are saying? ☐ Yes ☐ No

Does your child follow simple directions? ☐ Yes ☐ No

Does your child respond correctly to yes/no questions? ☐ Yes ☐ No

Does your child respond correctly to who/what/where/when/why questions? ☐ Yes ☐ No

How does your child currently communicate with you?

- ❑ Body Language
- ❑ Pointing
- ❑ Single Words (mom, dad, dog, up)
- ❑ 2-4-word sentences
- ❑ Sounds (Vowels, grunting)
- ❑ Other : _____

Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

Is your child aware of, or frustrated by, any speech/language difficulties? ☐ Yes ☐ No

School History

Does your child currently attend school? ☐ Yes ☐ No

Which school? _____

What grade? _____

Which subjects are your child's strengths or best subjects in school? _____

_____

Is your child having difficulties in any subjects at school? ☐ Yes ☐ No

Which ones? _____

Is your child receiving any help at school? ☐ Yes ☐ No

Describe: _____

What do you see as your child's most difficult problem in school? _____

_____

Summary

What are your child's strengths?

What are your child's weaknesses?

What are your goals for therapy?

Please list any additional information that may help us understand your concerns about your child's development.

Appointment Times

Preferred Times: Please specify which days/times you would prefer for therapy. We will make an effort to use your preferred times if possible.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
7am – 8am	☐	☐	☐	☐	☐	☐	Closed
8am – 9am	☐	☐	☐	☐	☐	☐	Closed
9am – 10am	☐	☐	☐	☐	☐	☐	Closed
10am – 11am	☐	☐	☐	☐	☐	☐	Closed
11am – 12pm	☐	☐	☐	☐	☐	☐	Closed
12pm – 1pm	☐	☐	☐	☐	☐	☐	Closed
1pm – 2pm	☐	☐	☐	☐	☐	☐	Closed
2pm – 3pm	☐	☐	☐	☐	☐	☐	Closed
3pm – 4pm	☐	☐	☐	☐	☐	☐	Closed
4pm – 5pm	☐	☐	☐	☐	☐	☐	Closed
5pm – 6pm	☐	☐	☐	☐	☐	☐	Closed

Cannot Attend Times: Please specify which days/times you absolutely cannot attend. We will not schedule you for the times below.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
7am – 8am	☐	☐	☐	☐	☐	☐	Closed
8am – 9am	☐	☐	☐	☐	☐	☐	Closed
9am – 10am	☐	☐	☐	☐	☐	☐	Closed
10am – 11am	☐	☐	☐	☐	☐	☐	Closed
11am – 12pm	☐	☐	☐	☐	☐	☐	Closed
12pm – 1pm	☐	☐	☐	☐	☐	☐	Closed
1pm – 2pm	☐	☐	☐	☐	☐	☐	Closed
2pm – 3pm	☐	☐	☐	☐	☐	☐	Closed
3pm – 4pm	☐	☐	☐	☐	☐	☐	Closed
4pm – 5pm	☐	☐	☐	☐	☐	☐	Closed
5pm – 6pm	☐	☐	☐	☐	☐	☐	Closed

Notes / Requests regarding appointment times:

Policies and Terms of Service

Cancellation and No-Show Policy: Your child's therapy is very important, and Hearts and Hands Therapy Services wants to provide the most effective services to all clients and regular attendance at therapy sessions is critical to your child's success. We are committed to helping improve your child's overall development, but your child's progress will be hampered if too many sessions are missed.

We understand that sometimes a session must be canceled due to illness or other conflicts, but we ask that you give your therapist at least 24 hours' notice of any cancellations. If you need to cancel your child's appointment on the same day as the therapy, *please call your child's therapist as soon as possible.* If you are not able to reach him/her, please leave a message on

their phone and call the office so that we can try to notify them as well. If therapy is cancelled less than 24 hours in advance or we do not receive notice of the cancellation, you may be charged a cancellation fee of $30 for the missed session.

In addition, if there are a significant number of missed sessions due to cancellations, no shows, or any other reason, your child may be discharged from therapy or placed on a waiting list for continued services. In most cases, more than 2 missed sessions in a 60-day period will result in a review and possible discharge or transfer to the waiting list.

It is your responsibility to contact your therapist if you must cancel the therapy session or have a problem with your child's appointment.

Consent for Treatment: By signing this form, you consent for Hearts and Hands Therapy Services, Inc. to treat your child as requested above. You consent to care and treatment that falls within the scope of therapy practice as defined by the State of Georgia. You further agree that you understand that the practice of medicine, including Occupational, Physical, Speech, and Behavioral therapy, is not an exact science and that the treatment will involve physical participation on the part of the child. By signing this form, you acknowledge that you have read and understand the contents and are competent to execute it, and, if executed on behalf of another, that you are authorized to execute it on behalf of that person.

Authorization to Bill Insurance and Acceptance of Liability: You understand and agree that Hearts and Hands Therapy Services, Inc. will bill your insurance, if available. If coverage is denied, or the amount paid by insurance is less than the full amount owed, you understand and agree that you will be personally responsible to pay any outstanding amounts. You further agree that the courts of Cherokee County, Georgia will have exclusive jurisdiction and venue over any legal action or claim to collect any amount owed. Further, you understand and agree that you will be responsible for reasonable attorney's fees if legal action is filed to collect a debt.

Child's Name: _____

Parent or Guardian Signature: _____ Date: _____

Policies and Terms of Service (continued)

Credit Card on File Agreement: It is our policy that all Hearts and Hands Therapy Services (HHTS) clients to keep a credit card on file for payment purposes. Our system enables us to maintain your credit card information securely on file and can only be accessed under the terms specified below.

By providing us with your credit card information you are giving HHTS permission to automatically charge your credit card if payment is not made by you within 30 days of your invoice. Please note there is a 5% late fee after your invoice is over 30 days old.

The billed amounts will match the patient responsibility amount as determined by your insurance. There are no co-pays or fees for services if you have Medicaid or Deeming Waiver Medicaid as primary or secondary insurance.

You agree to notify HHTS immediately in the event of loss of Medicaid coverage. Failure to do so will result in potential charges to you at the Medicaid Rate.

Please note that any missed appointment without cancellation will result in the credit card on file being charged the no-show fee of $30.00.

If a charge is declined you will be asked for a new credit card number and or payment before continuing therapy services.

I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE HHTS TO CHARGE MY CREDIT CARD AS ABOVE STATED ABOVE.

Child's Name: _____

Parent or Guardian Signature: _____ Date: _____

Type of Card: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Name on Credit Card: _____

Billing Address:_____

City: _____ State_____ Zip code: _____

Credit Card Number: _____ Exp. Date: _____

Security Code: _____

_____ *Initial here if you would like all invoices to be billed to above credit card.*

Please check one: ❑ bill weekly ❑ bill monthly

Photo Consent Form

We occasionally will take pictures or videos of therapy sessions for instructional and/or marketing purposes. We would appreciate your permission to use images or videos of your child. We will never sell or transfer ownership of any such images or videos.

Please initial one of the two options below:

(Initials)

_____ I **AUTHORIZE** the taking and use of photographs or videos of my child for instructional and/or marketing purposes, including social media posts, websites, magazines, photographs, flyers, or other similar publications.

_____ I **DO NOT AUTHORIZE** the taking and use of photographs or videos of my child.

Parent/ Guardian Signature: _____ Date: _____

Privacy Practices and Procedures Acknowledgement Form

By signing below, you acknowledge that you understand that Hearts and Hands Therapy Services, Inc. may be provided access to, or create on your behalf, certain protected, identifiable, health information and that you have certain rights to the restriction of disclosure and use of such information.

You further acknowledge that you were presented with a copy of Hearts and Hands Therapy Services, Inc.'s HIPAA Notice of Privacy Practices pursuant to HIPAA and 45 C.F.R. Parts 260 and 164 and applicable state law. You agree that you have reviewed the notice and understand its terms or have been provided an opportunity to have the same explained to you.

Parent/ Guardian Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1) Hearts and Hands Therapy Services, Inc., hereinafter HHTS, is permitted to make use of and to disclose health care information for the purposes of treatment, payment, and health care operations. The following are examples of use or disclosure for each of the listed purposes:
   A) Example of use or disclosure for the purpose of treatment: Private health information may be disclosed to gain knowledge about our diagnosis or prognosis to help us treat your condition appropriately.

B) Example of use or disclosure for the purpose of payment: Private health information may be disclosed so that we may collect payment from your insurance company or other healthcare coverage.
C) Example of use or disclosure for the purpose of health care operations: Hearts and Hands may contact the individual to provide appointment reminders, information about your treatment alternatives or other health related benefits services that may be of interest to the individual.

2) HHTS is permitted or required to use or disclose protected health information without the individuals written authorization for the following purposes:
A) To maintain a directory of individuals.
B) To a family member, other relative or a close friend of the individual, or any other person identified by the individual, to the extent disclosure is directly relevant to the individual's care or payment related to the individual's care.
C) To notify a family member, a personal representative of the individual or another person responsible for the care of an individual of the individual's location, general condition or death.
D) Where necessary, to assist a public or private entity authorized by law or by its charter, in disaster relief efforts.
E) Where the disclosure or use is required by law.
F) To assist the public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability.
G) To assist a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.
H) To provide information regarding a person subject to the jurisdiction of the Food and Drug Administration with respect of an FDA regulated product or activity for which that person has responsibility.
I) Where authorized by law to notify an individual, who may have been exposed to a communicable disease or may otherwise by a risk of contracting or spreading a disease or condition.
J) To an employer to conduct an evaluation relating to medical surveillance in the workplace or evaluate whether the individual has suffered a work-related illness or injury and where evaluation notice of such disclosure is given to the individual.
K) Where made to a government authority about an individual reasonable believed to be the victim of abuse or neglect.
L) To a health oversight agency for oversight activities authorized by law.
M) Pursuant to a court order or properly restricted subpoena upon notice.
N) To a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
O) To a law enforcement official for the purpose of identifying who is or is suspected to be the victim of a crime.
P) To a law enforcement official regarding a death if there is reason to believe the death resulted from criminal conduct.

Q) To law enforcement official if the information constitutes evidence that a crime has occurred on HHTS' premises.
R) To a law enforcement officer in response to a medical emergency, if necessary, to alert such officer to aspects of a crime.
S) To a coroner of medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties as authorized by law.
T) To funeral directors consistent with applicable law to carry out their duties with respect to the decedent.
U) To organ procurement organizations engaged in the procurement, banking or transplantation of organs, eyes, or tissue.
V) To assist, where necessary, for research purposes where adequate restrictions are in place.
W) Where necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or the public.
X) Where the individual is Armed Forces personnel and the information is deemed necessary by military command authorities to assure proper execution of military mission.
Y) Where the individual i s foreign military personnel a n d the information is deemed necessary by foreign Military command authorities to assure proper execution of the military mission.
Z) To authorized federal officials to conduct lawful intelligence gathering, counterintelligence, and other national security activities authorized by the National Security Act.
AA) To authorized federal officers for the provision of protective services to the President.
BB) To correctional institutions or authorized law enforcement officers for the provision of care of inmates and the safety and administration of the correctional facility.
CC) To the extent necessary to comply with law relating to workers' compensation or other similar programs; and
DD) Any other permitted purposes define in 45 C.F.R. Parts 160 and 164.

3) Other uses and disclosures of information will be made only with the individual's written authorization. The individual may revoke such authorization at any time provided that the revocation is in writing except to the extent that:
   A) HHTS has acted in reliance thereon, or
   B) If the authorization was provided as a condition to obtaining insurance coverage or the law permits the insurer the right to contact regarding the claim under the policy itself.
4) The individual retains the following rights with respect to protected information:
   A) The right to request restrictions on certain uses and disclosures of protected health information. HHTS is not required to agree to a requested restriction.
   B) The individual retains the right to receive confidential communications of protected health information about the individual.
   C) The individual retains the right to inspect and copy protected health information about the individual except for the following:

i) psychotherapy notes
ii) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding and
iii) protected health information subject to the Clinical Laboratory Improvements Amendments of 1988, to the extent the provision law or information would prohibit access to the individual exempt from the Clinical Laboratory Amendments of 1988.

D) The individual retains the right to amend protected health information so long as Hearts and Hands retains such information. HHTS retains the right to deny an individual's request to amend protected health information if it determines:
i) that the information to be amended was not created by HHHTS, unless the individual provides a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
ii) the information sought to be amended is not part of the designated set of the individual's record: HHTS determines that the record or information sought is accurate and complete.

E) The individual retains the right to receive an accounting of disclosures of protected health information made within six (6) years prior to the date on which the accounting is requested except for disclosures:
i) Made to carry out treatment, payment, and health care operations.
ii) Made to an individual upon that individual's request of protected health information about that individual.
iii) Made incident to a use or disclosure otherwise permitted or required by law.
iv) Made pursuant to an authorization provided but not in the Notice.
v) Made for the facility's directory or to persons, such as an individual's care or otherwise entitled to notification.
vi) Made for national security or intelligence purposes.
vii) Made to correctional institutions or law enforcement official.
viii) Made as part of a limited date set that does not contain identifying information regarding the individual; or
ix) Made prior to the effective compliance date of HHTS original notice.

F) The individual including any individuals who have agreed to receive the Notice electronically, retain the right to obtain a copy of the Notice from HHTS upon request.

G) HHTS is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

H) HHTS is required to abide by the terms of the Notice currently in effect.

I) HHTS reserves the right to change the terms of its notice and to make the new notice and provisions effective for all protected health information that it maintains. In the event that HHTS seeks to apply a change in a privacy practice that is described in the Notice to protect health information that Hearts and Hands created or received prior to issuing a revised notice, Hearts and Hands shall provide individuals with a revised notice by handout or mail.

J) Individuals may complain to HHTS and to the Secretary of Health and Human Services if they believe their Privacy rights have been violated. If an individual chooses to file a complaint with Hearts and Hands, he/she may do so in the following manner: written complaint/notice. The individual will not be retaliated against for filing a complaint.

K) If the individual desires further information concerning his/her privacy rights under this Notice, they may contact:

Hearts and Hands Therapy Services, Inc
1-844-543-8437
2001 Professional Pkwy, Suite 220
Woodstock, GA 30188.

L) This Notice first went into effect on the 1st Day of May 2008. This date is not earlier than the date on which the Notice has been printed or otherwise published.