BUILDING BLOCKS
PEDIATRIC THERAPY, LLC

2261 Deer Pointe Drive - Clarkston, WA 99403

Phone: (509) 202-0966 / Fax: (208) 906-8599

WELCOME!!!

Hi There,

My name is Jamie Larsen, owner of Building Blocks Pediatric Therapy, LLC and I wanted to take a moment to thank you for choosing us to provide services for your child. We appreciate you welcoming us into your home and other natural settings so we may get a full picture of your child and see how they are participating using their physical skills, fine motor skills, language skills and/or feeding skills.

I have enclosed some initial paperwork that is necessary to begin our process. Some of the paperwork does not have to be filled out but is yours to keep including our Patient Rights and Summary of Privacy Act and our hand out on Advance Directives. In order to get started, we need to have the following documents on file: The Billing Contact Form, Authorization/Release of Information and the Consent Form. All forms are now able to bee completed through Adobe. You can download Adobe Fill & Sign for free on any device, fill out and sign the forms and then email them back to us at admin@buildingblockspt.com. Our email system is secure! When you email the forms back, please also include a picture of your child's insurance card, both front and back.

When we have your information in our system, you will be added to a therapist (or possibly a waitlist). Once assigned to a therapist, you will receive a call from them to set up and complete the evaluation. Therapists would like to have a parent/guardian present to interview during this process. Once the evaluation is completed, if the therapist feels therapy will be beneficial, they will establish a schedule at that time.

If at any time you have any questions or concerns, please feel free to call me at 509-499-3483, or our main office line 509-202-0966.

Thank you again for trusting us with your child, we look forward to meeting you and your family.

Jamie Larsen, DPT

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Billing Contact Sheet

Patient Name: _____ DOB: _____ M/F_____

Parent: _____Phone: Home _____Cell _____

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

SS#: _____

Responsible Party:
Name(s):_____ DOB: _____

Address (If different from above):_____

Phone: (If different from above):_____

SS#:_____

Primary Insurance _____, ID# _____
Group #_____
Subscriber name/relationship to child: _____

Secondary Insurance _____, ID# _____
Group # _____
Subscriber name of secondary/ relationship to child: _____

Therapist:
Therapist NPI:
Group NPI: 1720402431

Parent Signature: _____ Date: _____
Parent name of who signed paperwork _____Date: _____

Referring Doctor and NPI:_____

☐ Insurance Authorization (provided attached)

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Case History Form

Child's name: _____
DOB: _____
Parent's names:

Allergies:

Medications Currently being taken:

GENERAL INFORMATION
School/Preschool:

People living in household:

Primary language(s) spoken in home:

Parent concerns:

Has anyone else expressed concerns?

Previous therapies:

MEDICAL HISTORY
Problems or unusual stresses during pregnancy:

Problems after birth (jaundice, required O2, etc):

Birth weight:
Early or Late:

Did child come home with family as expected?
Any unusual problems during the first few weeks of life:

HEALTH
Hearing checked? ☐

Vision checked? ☐

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Child's name: _____
DOB: _____

History of:

- Ear problems ☐
- Diagnosed medical, physical, or emotional problems ☐
- Exposed to illegal substances ☐
- Emotionally or physically abused ☐

Developmental Milestones:

- Sit up independently
- Crawl
- Walk alone
- Speak first word
- Put several words together
- Dress self
- Finger feed self
- Eat with utensils
- Toilet trained

Daily behavior:

- Socializing concerns
- Feeding concerns
- Sleeping concerns

Get along with other children?

How does s/he communicate?

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Authorization/Release Form

AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I give my consent for to obtain medical, developmental, and school records for _____from the following professionals. I further give my consent to disclose and release care information for_____ to the below named professionals:

Contact Name	**Address**	**Telephone**
Doctor (Primary):		
Doctor (Other):		
Hospital:		
Public Health Nurse:		
School District:		
ESIT/ Early Intervention Program:		
Other:		

This authorization expires 365 days after the last date it was signed. It can be renewed. A copy of this document may be considered the same as the original.

Date	

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Consent Form

Patient Name:	**Date of Birth:**
Consent to Bill	***Initial:***

I hereby authorize Building Blocks Pediatric Therapy, LLC to bill my insurance company for direct reimbursement of therapy services rendered to my child. Benefit payment will be assigned directly to Building Blocks Pediatric Therapy, LLC.

Consent to Treat	***Initial:***

I understand that my child has a diagnosis requiring Physical Therapy (PT), Occupational Therapy (OT) and/or Speech and Language Therapy (ST) evaluation and/or treatments, and voluntarily consent to such care for my child by Building Blocks Pediatric Therapy, LLC, as may be beneficial in the professional judgment of the child's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of PT, OT, ST on my child.

I am aware that Building Blocks Pediatric Therapy, LLC, provides educational opportunities for students. Students and other health care professionals may attend treatment sessions to learn and observe treatments being performed or led by my child's PT, OT, ST. I give my consent for other professionals and students to participate in treatment sessions. I have the right to withdraw this consent on any day if I choose to do so.

I am aware that Building Blocks Pediatric Therapy, LLC may find telehealth to be an appropriate way to deliver therapy services, and give consent to do so when necessary.

Cancellation Policy	***Initial:***

Building Blocks Pediatric Therapy, LLC requires 24 hour notice for all cancellations. If your child misses a scheduled session and you have not called to give notification that the session would be missed, it is considered a "no show". After three cancellations without proper notification or no shows, your child will be discharged from therapy, you and your child's primary care physician will be notified, and your child will be placed on a waiting list to resume services when appropriate.

Acknowledgement of Receipt of Privacy Policy & Patient Rights	***Initial:***

I acknowledge that I have read and received a copy of Building Blocks Pediatric Therapy, LLC Notice of Privacy Policy Practices with an effective date of 4/15/2011, as it relates to my child.

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Patient Rights/HIPPA Document

Patient Rights

Every patient has the right to:

- A listing of the services offered by Building Blocks Pediatric Therapy, LLC and those being provided
- The name of the individual supervising the care and the manner in which that individual may be contacted
- Physical Therapy Supervisor:
  - Jamie Larsen, DPT (509)499-3483
- A description of the process for submitting and addressing complaints
- Submit complaints without retaliation and to have the complaint addressed by the licensee
- Be informed of the state complaint hotline number
- Department of Health Facilities and Services Licensing complaint hotline:
- 1-800-633-6828 (WA) or 1-208-334-6626 (ID)
- A statement advising the patient or client, or designated family member of the right to ongoing participation in the development of the plan of care
- A statement providing that the patient or client, or designated family member is entitled to information regarding access to the department's listing of providers and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations
- Be treated with courtesy, respect, privacy, and freedom from abuse and discrimination
- Refuse treatment or services
- Have property treated with respect
- Privacy of personal information and confidentiality of health care
- Be cared for by properly trained personnel, contractors and volunteers with coordination of services
- A fully itemized billing statement upon request, including the date of each service and the charge. Licensees providing services through a managed care plan are not required to provide itemized billing statements
- Be informed about advanced directives and the licensee's responsibility to implement them

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Summary of Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is effect. This Notice takes effect 11/20/08 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment, and health care operations. For example:

Treatment: We may use and disclose your health information to a physician or other health care provider providing treatment to you.

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

Health care operations:

We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence and qualification of health care professionals, evaluating practitioner performance, conducting training programs, accreditation, certification licensing, and credential activities.

Your authorization: In addition to our use of your health information for treatment payment or health care operations your may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any

reason except those described in this Notice.

To your family and friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your heath information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for you health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses and disclosers. In the event of your incapability or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may only disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail message messages, postcards, or letters.)

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Right to Express Complaints: If you are concerned that we may have violated your privacy rights you may complain to us directly or by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and/or with the U.S. Department of Health and Human Services.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C., 20201
1-877-696-6775 (toll-free)

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FamilyDoctor.org

Advance Directives and Do Not Resuscitate Orders

What is an advance directive?
An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.
A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.
Advance directives can take many forms. Laws about advance directives are different in each state. You should be aware of the laws in your state.
What is a living will?
A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.
What is a durable power of attorney for health care?
A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.
Living wills and DPAs are legal in most states. Even if these advance directives aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer or state representative about the law in your state.
What is a do not resuscitate order?
A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. Unless given other instructions, hospital staff will try to help any patient whose heart has stopped or who has stopped breathing. You can use an advance directive form or tell your doctor that you don't want to be resuscitated. Your doctor will put the DNR order in your medical chart. Doctors and hospitals in all states accept DNR orders.
Should I have an advance directive?
By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.
People who are seriously or terminally ill are more likely to have an advance directive. For example, someone who has terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and

if you already have a signed advance directive, your wishes are more likely to be followed.

How can I write an advance directive?

You can write an advance directive in several ways:

- Use a form provided by your doctor.
- Write your wishes down by yourself.
- Call your health department or state department on aging to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

Can I change my advance directive?

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

Other Organizations

- AARP Advance Directive Information
- U.S. Living Wills Registry

Written by familydoctor.org editorial staff
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Physician Orders for Life-Sustaining Treatment (POLST) Information:

If you have a serious health condition, you need to make decisions about life-sustaining treatment. Your physician can use the Physician Orders for Life-Sustaining Treatment (POLST) to represent your wishes as clear and specific medical orders, indicating what types of life-sustaining treatment you want or do not want at the end of life.

POLST is not for everyone. POLST is designed for seriously ill individuals, or those who are in very poor health, regardless of their age. POLST complements an advance directive and is not intended to replace that document. An advance directive is still necessary to appoint a legal health care decision-maker, and is recommended for all adults, regardless of their health status. And unlike an advance directive, POLST must be signed by both the patient and the attending physician, nurse practitioner or physician assistant-certified. The attending physician, ARNP or PA-C who signs the form assumes full responsibility for its accuracy.

Completing a POLST is always voluntary. Learn more about POLST in the FAQ sections at bottom.

POLST and WSMA's other advance planning resources are offered as part of WSMA's award-winning Know Your Choices, Ask Your Doctor initiative, which focuses on the importance of conversations between physicians and their patients and giving physicians the tools to help patients make informed health care decisions. Learn more about about Know Your Choices, Ask Your Doctor.

How to obtain POLST

Patients are encouraged to ask their physicians for the form, but may also obtain a form by sending a self-addressed, stamped envelope to WSMA, Attn: POLST, 2001 6th Ave., Suite 2700, Seattle, WA 98121.

Health care professionals may order a supply of POLST forms as well as a tri-fold patient information brochure on POLST below (POLST materials are free for WSMA members. Limited quantities are available to clinics and hospitals. A small fee is charged for non-members).

Health professionals may choose to print their own copies of POLST. Download the POLST form-for-print. While we advise that you print the form on green card stock (Astrobrights terra green, smooth finish, 65 lbs., #22781, or an equivalent), it's not required.

Additional POLST information, including educational videos and Spanish language resources, are available in the POLST Information for Health Professionals section below.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth ____ ____ ____

Last 4 #SSN (optional) ____ ____ ____ ____

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

Check One

When not in cardiopulmonary arrest, go to part B.

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNAR (Allow Natural Death)**
Choosing DNAR will include appropriate comfort measures.

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

Check One

☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.**
Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

Additional Orders: (e.g. dialysis, etc.) _____

C SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Other as authorized by RCW 7.70.065 ☐ Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name	Phone Number
	✗ Physician/ARNP/PA-C Signature ***(mandatory)***	Date ***(mandatory)***
PRINT — Patient or Legal Surrogate Name		Phone Number
✗ Patient or Legal Surrogate Signature ***(mandatory)***		Date ***(mandatory)***

Person has: ☐ Health Care Directive (living will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

WASHINGTON

WSMA | Washington State Medical Association
Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient and Additional Contact Information (if any)

Patient Name (last, first, middle)	Date of Birth	Phone Number
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number

D NON-EMERGENCY MEDICAL TREATMENT PREFERENCES

ANTIBIOTICS:

☐ Use antibiotics for prolongation of life.

☐ Do not use antibiotics except when needed for symptom management.

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

☐ No medically assisted nutrition by tube.

☐ Trial period of medically assisted nutrition by tube. (Goal: _____)

☐ Long-term medically assisted nutrition by tube.

ADDITIONAL ORDERS: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

✘ Physician/ARNP/PA-C Signature	Date
✘ Patient or Legal Surrogate Signature	Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

NOTE: A person with capacity may always consent to or refuse medical care or inverventions, regardless of information represented on any document, including this one.

Completing POLST

- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.

For more information on POLST visit www.wsma.org/polst.

OVER ▶