BUILDING BLOCKS
PEDIATRIC THERAPY, LLC
2261 Deer Pointe Drive - Clarkston, WA 99403
Phone: (509) 499-3483 / Fax: (208) 906-8599

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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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	Signature and Relationship (Parent/Guardian)

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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)

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

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