Helena Occupational Therapy Specialists, PLLC

104 W. Custer Ave ste 5

Helena, MT 59602

*Phone* (406) 422-7729 *fax* (406) 403-0588

CLIENT INFORMATION

Client’s legal name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip:\_\_\_\_\_\_

Home Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referral Source:\_\_\_\_\_\_\_\_\_\_

PARENT/RESPONSIBLE PARTY INFORMATION

Parent/responsible party name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_

Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to communicate via text? Y/N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to communicate via email? Y/N

Do we have permission to send email updates related to Helena Occupational Therapy Specialists and the services they provide? Y/N

Parent/responsible party name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_

Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to communicate via text? Y/N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to communicate via email? Y/N

Do we have permission to send email updates related to Helena Occupational Therapy Specialists and the services they provide? Y/N

INSURANCE INFORMATION:

 *Primary insurance Secondary insurance*

Name of health insurance company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Picture of insurance card:

**ATTENDANCE POLICY**

Please Initial each below:

\_\_\_\_\_\_\_1. **Cancellations**: We understand that illness and family emergencies occur. If you need to cancel your appointment, please call your primary OT at least 24 hours prior to your appointment.

\_\_\_\_\_\_\_2. **Therapy progress**: Most insurance companies require a certain level of therapy progression to continue coverage. As to not disrupt the therapy progression, you may be required to attend a make-up session within 7 days of your cancellation.

\_\_\_\_\_\_\_2. **No Show Policy/Termination**: After 3 non-verified cancellations and/or no shows, the provider reserves the right to terminate therapy services. The provider also reserves the right to terminate therapy services at any time for any reason.

\_\_\_\_\_\_\_3. **Late Arrivals**: Our goal is to provide the highest quality therapy during your time with us. We greatly appreciate your timely arrival to all scheduled appointments. If you are more than 15 minutes late, we will not be able to provide the quality care desired. You may be required to schedule a make-up session.

\_\_\_\_\_\_\_4. **Rescheduling**: If you or your primary therapist are unable to hold an appointment, a rescheduled appointment will be offered. This may be offered with a different OT or OTA, who can offer a session working on the same goals/treatment plan.

\_\_\_\_\_\_\_5. **Health & Safety**: For the safety of all our clients and staff, please give us a call 24 hours prior to your appointment to reschedule if you or anyone coming with you has a fever and/ or is contagious with any type illness, rash, disease, etc.

Need appointment reminders? **Please check one preferred method below**:

\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Text:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Responsible party(ies) Date

**PAYMENT POLICY**

\_\_\_\_\_\_\_1. **Insurance/Responsible Party**: You are responsible for all costs associated with your (or for whom you are responsible) evaluation and/or treatment with Helena Occupational Therapy Specialists, PLLC. Please provide the most current insurance information and cards to our office. As a courtesy, we will check coverage/benefits prior to sending claims to your insurance company. Ultimately, it is your responsibility to pay your account in full regardless of payments made or not made by your insurance company. In the event you do not have insurance, or your insurance company does not cover occupational therapy, it is your responsibility to pay your account in full and personally collect any unpaid balances from your insurance company. Please notify us if your insurance changes prior to your next appointment so we can make the appropriate changes so you can receive your maximum insurance benefits.

\_\_\_\_\_\_\_2. **Payment Policy/Late fee**: Payment is due at the time of service and/or upon receipt of invoice. A late fee of $50 will incur after 30 days. Payments not received after 120 days are subject to collections. You will be responsible for any and all charges accrued as a result of collection and/or legal services used to collect your debt.

Preferred method of invoicing (if applicable):

* Email (address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Mail (address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Responsible party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Responsible party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/Client name

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION**

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. This does not keep the information from being shared with more people once It leaves our office. This authorization is valid for no longer than one year. If you decide later that you do not want us to share your information anymore, you can sign the REVOCATION SECTION at the end of this form and return it to us.

Client’s Printed Name:                                                         Birth Date:

I give permission to Helena OT Specialists, PLLC **to share and or receive the information checked below** with:

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Information about my care and treatment with the above person or group
* Information from a certain time period (Specific Dates): From                To
* All Information relating to a certain event or injury and dates: (must specify event and or dates)

Event

Date of Event

* Other (Specify)

Client’s Signature:                                                                                                               Date:

Signature of Authorized Representative:                                                                                      Date:

Relationship of Authorized Representative:                                                                                Date:

Witness Signature:                                                                                                                        Date:

**PATIENT-PROVIDER E-MAIL COMMUNICATION CONSENT**

I have read and understand the information outlined in the Patient-Provider Email communication policy provided to me by Helena Occupational Therapy Specialists.

**NAME OF RESPONSIBLE PARTY (print)**

**E-MAIL ADDRESS(ES)**

**RELATIONSHIP to client**

**CLIENT NAME**

**SIGNATURE OF RESPONSIBLE PARTY DATE**

**PERMISSION TO TREAT**

As the responsible party and/or Guardian, I give Helena Occupation Therapy Specialists permission to treat:

**Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERMISSION TO RECORD AND/OR PHOTOGRAPH**

The use of recording and photography can be used as an adjunct to evaluation, assessment and treatment. The information captured is used solely for the purposes of documentation and/or assessment of progress. Helena Occupational Therapy Specialists will protect all videos and photographs and will follow all confidentiality rules for our patients. If recordings are taken, after reviewing the recording and using it as mentioned above, the data will be deleted. By signing below, you agree to allow yourself and/ or your dependent to be recorded and/or photographed.

Client/Guardian Signature Date

**HIPAA- PATIENT-PROVIDER PRIVACY CONSENT FORM**

I have reviewed the HIPAA Patient- Provider Consent Info Sheet. I have read and understand the ways in which my privacy will be protected. I have read and understand the procedures for emergencies, confidentiality, record keeping, insurance, billing, and I consent to treatment under the described conditions. I also authorize the release of information to my insurance company (if applicable) Please refer to HIPAA document included with these forms. For more information on HIPAA and the protection of your privacy please go to: www.hhs.gov/hipaa

**Client Signature (if over 18):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPPA DISCLOSURES**

Please take a moment to read about your rights under the Health Insurance Portability and Accountability Act and affirm the following authorizations for disclosure of protected health information.

Helena Occupational Therapy Specialists may use or disclose your PHI to carry out treatment, payment or other healthcare operations related to your care. Examples would be: medical consultations, referrals, and insurance claims on your behalf.

You have the right to:

Request access to yours/ your child’s health record at any time

Request corrections be made to your/ your child’s record

Request that all communications regarding your care be restricted from unsecure transmissions (Fax, Email, Voicemail) **TEXTING IS NOT HIPPA COMPLIANT.**

Complain about a perceived violation of your privacy to me, my licensing board, or US Office for Civil Rights

Refuse any of the following authorizations

I authorized Helena Occupational Therapy Specialists to release my health information including diagnosis and treatment if necessary, for other care providers, hospitals, labs or facilities to continue my/child’s care.

I understand my rights as a patient/ parent of patient and have received a notice of privacy practices.

**TEXTING**: I acknowledge that texting to and from Sara Schweitzer and her employees/students/assistants is **NOT HIPPA compliant.** If I choose to text and receive texts, I am releasing Sara Schweitzer and her employees/assistants of any liability regarding texting as non- HIPPA compliant communication.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_