

Spot On Therapy Group, LLC.

4840 Waller Road

Richmond, VA 23230

spotontherapygroup@gmail.com (804)893-5010

Cancellation and No-Show Policy

Effective 7/15/2015

Please understand that we typically have a waiting list of clients and families who need our services. Ours is an appointment-based business, and we depend on clients honoring their reserved appointment times. A 24-hour notice is required for all cancellations. If a 24-hour notice is not given, then a \$50.00 fee will be charged for each occurrence. A \$50.00 fee will also be charged for failure to show up for a scheduled appointment. After three cancellations with less than 24-hour notice and/or no show appointments, then you will lose your regularly scheduled appointment time and will be placed on the week-to-week scheduling list (e.g. you will have to call each week to schedule your appointment) or you or your child may be discharged from therapy at that time. ** Exceptions (illness, death in family, etc.) are made on a case-by-case basis.

I have read and understand this cancellation notice and agree to the terms.

Spot On Therapy Group, LLC requires that we have a credit card on file for all clients. You will be notified prior to any charge greater than \$50.00. Initials _____ Date _____

It is our desire to work with you as a team, and we look forward to working with you and/or your child.

Sincerely,

The Staff
Spot On Therapy Group

Client Name

Client or Parent Signature

Appointment Day/Time _____ Date Reviewed with Patient: _____

Treating Therapist _____ Therapist Initials: _____

Therapist's Contact Info: email: _____ Phone: _____

Spot On Therapy Group, LLC
Client Contact Information

Today's Date _____

Client Name: _____ DOB: _____
Social Security Number _____ Gender _____
Address: _____ City: _____
State _____ Zip _____ Email Address: _____
Home Phone: _____ Cell Phone: _____

Referred by:(name and title) _____
Primary Care Physician _____
Name of Practice _____
Address _____ Phone _____

If a child, parents please complete the following:

Mother's Name: _____ Occupation: _____
Address (if different from above) _____
Phone (if different from above): Home Phone _____ Cell _____
Work Phone: _____ Employer _____

Father's Name: _____ Occupation: _____
Address (if different from above) _____
Phone (if different from above): Home Phone _____ Cell _____
Work Phone: _____ Employer _____

In case of emergency contact:

Name _____ Phone _____
Relationship to client _____

Insurance/Payment Information

Person responsible for payment of services: _____
Insurance Company _____
Insured's Name _____ DOB _____
Insured's ID Number _____ Insured's Group Number _____
Client's relationship to insured _____
Insured's Social Security # _____

OFFICE USE ONLY

Insurance Deductible _____ Preauth required _____
Patient Copay or Coinsurance _____ Max Coverage per Year _____

SPOT ON THERAPY GROUP, LLC

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(804) 893-5010 spotontherapygroup@gmail.com

RELEASE OF INFORMATION AGREEMENT

Client Name _____ Date of Birth _____

I request and authorize Spot On Therapy Group, LLC to release/exchange health care information of the client listed above to:

Name _____

Phone _____ Fax _____

Business/Affiliation with Client _____

Address _____

City/State _____ Zip _____

This authorization applies to the following information (please be specific)

This authorization expires on _____

Name _____

Phone _____ Fax _____

Business/Affiliation with Client _____

Address _____

City/State _____ Zip _____

This authorization applies to the following information (please be specific)

This authorization expires on _____

Name _____

Phone _____ Fax _____

Business/Affiliation with Client _____

Address _____

City/State _____ Zip _____

This authorization applies to the following information (please be specific)

This authorization expires on _____

.....

Print client or guardian's name

If child, name of child

Client or guardian's signature

Date

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PRIVACY PRACTICES POLICY

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinicians or other treatment team members. *We may disclose PHI to any other consultant only with your specific written authorization.*

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support certain business activities including, but not limited to, sharing your PHI with third parties that perform various business activities (e.g., billing or typing services) only if we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Your PHI may be disclosed via email, if you have given written permission, for appointment reminders, and to provide information about treatment alternatives or other health-related benefits and services.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose information to family members that are directly involved in you or your child's treatment *with your verbal permission.*

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask for amendment of the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. ****Please notify Spot On Therapy Group, LLC if you would like a copy. Please also check the appropriate box on the signature page, indicating you received a copy of this notice.**

Spot On Therapy Group, LLC Written Acknowledgement Form

By signing this form, I acknowledge and agree as follows:

I have been given the opportunity to read Spot On Therapy Group's Notice of Privacy Practices policy statement prior to signing this acknowledgement form.

The Privacy Practices policy statement includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Spot On Therapy Group, LLC to treat me and/or my child and to obtain payment for that treatment.

_____ By initialing, I indicate that I would like a printed copy of Spot On Therapy Group's Notice of Privacy Practices Policy.

Name of Client

Date

Signature of Client or Parent/Guardian

Relationship to Client

Date Copy Provided to Client _____

Staff Initials _____

SPOT ON THERAPY GROUP, LLC
CLIENT/CHILD BACKGROUND INFORMATION

Date: _____

IDENTIFYING INFORMATION

Child's Name: _____ Age: _____ Birth Date: _____ Sex: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Daytime Phone: _____ Daytime Phone: _____

Cell Phone: _____ Cell Phone: _____

E-mail: _____ E-mail: _____

Primary Physician's Name: _____ Physician's Phone: _____

The child lives with: Birth Parents Adoptive Parents Foster Parents
 One Parent Siblings Parent and Step-parent
 Other: _____

REFERRING INFORMATION

Who referred this child? _____

Reason for referral: _____

May we have your permission to thank this person for the referral? Yes No

What are your primary concerns and/or goals regarding your child? _____

At what age did you begin to have these concerns? _____

In what settings does your child struggle? (i.e. home, school, store, etc.) _____

In what settings does your child do well? (i.e. home, school, store, etc.) _____

What are your child's strengths? _____

How would you describe your child? _____

MEDICAL HISTORY

Were there any difficulties during the pregnancy? Yes No

If yes, please explain: _____

Length of pregnancy: _____ Length of labor: _____

Birth was: Normal Caesarian Breech Multiples Weight: _____

Did your child experience any of the following complications during infancy?

Required breathing assistance Yes No

If yes, please explain: _____

Feeding difficulties Yes No

If yes, please explain: _____

Has your child had any of the following?

adenoidectomy

encephalitis

allergies

mumps

chicken pox

flu

colds

sinusitis

respiratory/breathing difficulties

head injury

sleeping difficulties

seizures

high fevers

thumb/finger sucking

scarlet fever

measles

cardiac problems

meningitis

vision problems

ear tubes

tonsillectomy

tonsillitis

ear infections – how often? _____

other surgeries: _____

other hospitalizations: _____

Please check all of the following whom you have contacted and/or from whom you have received services concerning your child.

| <u>Area of Service</u> | <u>Clinician</u> | <u>Date</u> | <u>Diagnosis/Recommendations</u> |
|--|------------------|-------------|----------------------------------|
| <input type="checkbox"/> Occupational Therapists | _____ | _____ | _____ |
| <input type="checkbox"/> Physical Therapist | _____ | _____ | _____ |
| <input type="checkbox"/> Speech Language Pathologist | _____ | _____ | _____ |
| <input type="checkbox"/> Developmental Pediatrician | _____ | _____ | _____ |
| <input type="checkbox"/> Vision Specialist | _____ | _____ | _____ |
| <input type="checkbox"/> Hearing Specialist | _____ | _____ | _____ |
| <input type="checkbox"/> Behavior Specialist | _____ | _____ | _____ |
| <input type="checkbox"/> Neurologist | _____ | _____ | _____ |
| <input type="checkbox"/> Orthopedist | _____ | _____ | _____ |
| <input type="checkbox"/> Psychologist | _____ | _____ | _____ |
| <input type="checkbox"/> Counselor | _____ | _____ | _____ |
| <input type="checkbox"/> Other: _____ | _____ | _____ | _____ |

Is your child currently on medication? Yes No If yes, please specify:

| <u>Name of Medication</u> | <u>Purpose</u> |
|---------------------------|----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please list any previous medications: _____

Does your child have specialized equipment? Yes No

If yes, please specify: _____

DEVELOPMENTAL HISTORY

Please check whether your child's skill achievement was "on time," delayed or is not yet mastered. Age ranges for typical development are in parentheses.

| <u>MOTOR:</u> | <u>On time</u> | <u>Delayed</u> | <u>Not yet mastered</u> |
|----------------------------------|--------------------------|--------------------------|--------------------------|
| Head control (3mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reaching for objects (3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Roll over both ways (7-8 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Finger feeding (7-8 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting alone (7-9 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Creeping on all 4's (9 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pulling to stand (9 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating with spoon (1-1.5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking (1-1.5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Jumping (2-3 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hopping on one foot (3-4 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drawing a circle (3-4 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cutting with knife (5-6 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cutting with scissors (5-6 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Riding a bike (5-6 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Does your child have difficulty learning new motor skills? Yes No

If yes, please explain: _____

| <u>LANGUAGE:</u> | <u>On time</u> | <u>Delayed</u> | <u>Not yet mastered</u> |
|--|--------------------------|--------------------------|--------------------------|
| Looks/responds when called (6-9 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Looks in direction that others point (9-12 mos.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Said first word (1-1.5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pointing to simple pictures (1-1.5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Following one step commands (1-1.5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Combined words (1.5-2 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Following several step commands (1.5-2 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spoke sentences (2-2.5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| <u>SELF-HELP:</u> | <u>On time</u> | <u>Delayed</u> | <u>Not yet mastered</u> |
|------------------------------------|--------------------------|--------------------------|--------------------------|
| Bladder control (3 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel control (3 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Toileting independently (3-4 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Snaps independently (4 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Buttons independently (4-5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Zips independently (4-5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing independently (4-5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brushing teeth (4-5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tying shoes (5 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brushing/combing hair (6-7 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bathing independently (6-7 yrs.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

BEHAVIOR DURING INFANCY

Please select the characteristics that describe(d) your child as an infant:

| | <u>Yes</u> | <u>No</u> | <u>Sometimes</u> | | <u>Yes</u> | <u>No</u> | <u>Sometimes</u> |
|-------------------------------|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------------------|
| Cried a lot, fussy, irritable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liked being held | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Overly demanding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resisted being held | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alert | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Floppy when held | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Quiet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tense when held | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Passive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Good sleep pattern | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Active | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular sleep pattern | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CURRENT BEHAVIOR

Please select the characteristics that describe your child at present:

| | <u>Yes</u> | <u>No</u> | <u>Sometimes</u> | | <u>Yes</u> | <u>No</u> | <u>Sometimes</u> |
|-----------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--------------------------|
| Mostly quiet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clumsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Overly active | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Struggles with separation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tires easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous habits/tics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Talks constantly | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Falls often | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Overly impulsive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wets bed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restless | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wets/soils pants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stubborn | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has poor attention span | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Resists change | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frustrated easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fights often | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has unusual fears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Usually unhappy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has frequent temper tantrums | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physically aggressive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seems anxious | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Toward whom? _____

SCHOOL HISTORY

What is your child's hand preference? Right Left Both

What is your child's current school/grade level? _____

What are your child's strengths in school? _____

Is your child having any difficulties in school? Yes No

 If yes, please explain: _____

Is your child in a special class or receiving any support services? Yes No

 If yes, please specify: _____

Has your child repeated any grade levels? Yes No

 If yes, please specify: _____

What does the teacher say about your child? _____
