Developmental Steps, LLC
388 Westchester Avenue, Suite 1A-1B
Port Chester, New York 10573
914-939-6400

Please complete and return this form before your child's first session at Developmental Steps or as an update.

Date: _____

Child's Name: _____ DOB: _____
last first

Address: _____

Parents Names: _____
mother father

Home Telephone: _____
area code

Cell: (Mother) _____ (Father) _____
area code area code

Work: (Mother) _____ (Father) _____
area code area code

Email contact _____ mother/father

Babysitter/Caretaker _____ Cell: _____
area code

Referred By _____

Pediatrician _____ Phone: _____
area code

Allergies/Alerts/Restrictions: _____

_____

I have received a copy of the HIPPA regulations:
Name _____ Signature _____ Date: _____

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Developmental Steps, LLC
Informed Consent and Policies Agreement

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your child's condition interfere with the quality of his/her life?
2) Does your child's condition interfere with his/her ability to participate in daily activities?
3) Is your child motivated and able to participate in his/her treatment program and follow home and self-care instruction?
4) Is there potential for your child's condition to improve and/or resolve? If not, is there potential for your child's function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services such as sports specific/ strengthening programs, individual or group fitness/exercise training, and infant, child or teen wellness programs, etc. payable out-of-pocket by cash, check or credit card.

Cancel/No-show/Late

If you wish to change or cancel an appointment, we require a minimum of 24 hour notice. If you cancel within the 24 hour period of your appointment for any reason, our cancellation fee is $25. Advance notice allows someone else time to reserve it in your place. Please be courteous and responsible. If you fail to show for your appointment without notice, you will be charged a fee of $75, no exceptions.

Results

The purpose of physical/occupational therapy is to maximize your child's own healing potential through natural means and promote his/her ability to perform daily, leisure, and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients

It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Minors and Parents

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent

By signing below, the patient/caregiver gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caregiver to inform the therapist/staff about any health problems or allergies patient may have. Patient/caregiver must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration

The therapist has explained to me the type of treatments ideal for my child's condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

_____
Patient Signature/Date

_____
Patient's Representative Signature/Date

_____
Witness Signature/Date

_____
Relationship to Patient

Developmental Steps, LLC

Statement of Privacy Notice

Effective October 15, 2014

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

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (914) 939-6400. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (914) 939-6400. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Developmental Steps, LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Parent's Name (print)

_____
Parent's Signature Date

_____
Authorized Facility Signature Date