I have been informed to the use and release of information collected through services received in regards to: _____ (patient name). I hereby give permission for my child's medical information to be released to and from Holy City Pediatric Therapy, LLC with the below providers, agencies, and/or caregivers that are involved with the care of my child.

Pediatrician Name & Office:	Baby Net Provider/Early Interventionist:
Insurance to Be Billed (Primary and/or Secondary):	Outside Professionals/ School / Daycare:
Employees & Billing Manager of: Holy City Pediatric Therapy	OTHER (caregivers, grandparents, etc.):

Specific information to be released or obtained: medical information pertaining to the child's Speech, Physical, and/or Occupational Therapy plan of care(s). This includes but is not limited to: daily treatment notes, progress notes, evaluations and access to patient portal on electronic documentation system, Fusion Web Clinic.

I am the client, parent or authorized representative and understand that I am responsible for this information if it is released to me. I also understand that my records are protected generally under state laws, as well as statutes governing specific types of information and cannot be disclosed without my consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken on it.
I hereby acknowledge that I have received a copy of The Notice of Privacy Practices by Holy City Pediatric Therapy, LLC. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purpose of treatment, payment and healthcare operations.

Payment Policy and Billing Procedures: Your insurance will be verified and filed for services rendered as a courtesy to you; **however, we cannot guarantee payment. You are responsible for any amount not covered by your insurance company.** We have an agreement with you, not your insurance company for receipt of payment. Please be aware of this policy and your insurance company policy so that you can plan accordingly. If applicable, I give Holy City Pediatric Therapy, LLC permission to bill Medicaid or any other insurance company for services rendered.

Consent for Treatment: I understand that my child has been referred for therapy services with Holy City Pediatric Therapy, LLC. I consent to have these services provided as prescribed by my child's physician and/or recommended by the therapist.

I authorize Holy City Pediatric Therapy, LLC to furnish my insurance company(s) with any information that may be required in order to determine benefits and process claims. I authorize payment of medical benefits to Holy City Pediatric Therapy and Dustin Tolley DPT (owner) for services rendered to me. I certify by my signature that I have read the above and agree to these policies.

Signature:_____Date:_____

Office Phone: 843-696-2174
Office Fax: 888-659-8008
Office Address: 142 Sportsman Island Drive Suite E Charleston, SC 29492

Witness:_____ **Date:**_____

Electronic Communication Consent Form

Patient's Name: _____ **Patient's D.O.B:**_____

I, _____**(Caregivers Name)** allow my therapist(s) with to Holy City Pediatric Therapy, LLC communicate with me regarding my child's care via e-mail.

Email Address: _____

☐ **By checking this box, I would like to establish a "Patient Portal" to view my child's treatment documents.**

SIGNATURE:_____

Please indicate any information below that you would not like to be communicated via email:

PHOTO & VIDEO RELEASE CONSENT FORM

_____ **YES!** I give permission for my child's photograph or video to be taken and potentially posted to our company website/Facebook/Instagram page.

_____ **YES!** For therapy purposes, ONLY!

Office Phone: 843-696-2174
Office Fax: 888-659-8008
Office Address: 142 Sportsman Island Drive Suite E Charleston, SC 29492

_____ **NO!** I do not give permission for my child's photograph or video to be posted or to be used to track progress of treatment.

Signature:_____**Date:**_____

Witness:_____ **Date:**_____

Cancellation Policy

✔ It is very important for your child's progress that therapy be attended on a consistent basis. Our treatment sessions will be set up on a weekly or biweekly scheduled day and time in order to set up a routine for your family. Please make every effort to make these sessions a top priority. If scheduling conflicts arise, please contact the office or your therapist in order to schedule a makeup session. This should be done as soon as you are aware of the conflict in scheduling.

✔ If for any reason you are unable to keep your scheduled therapy time you are required to contact the office or your therapist with Holy City Pediatric Therapy, LLC via phone call, text, or email within 5 hours of your scheduled therapy time. It is preferred that you contact the office or your therapist as soon as you are aware of the need to cancel your appointment. Please inform them1 week in advance of any scheduled trips, camps, etc… that may require a missed appointment.

✔ If your therapist arrives at your home or your child's daycare facility and he/she is not available for therapy this is considered a **"NO SHOW."** It is also considered a **"NO SHOW"** if you are not present within 15 minutes of your scheduled appointment time at the outpatient clinic. **If for <u>any</u> reason your child has 3 "no shows" within a 6 month time period, he/she will be discharged from services.**

✔ A **"NO SHOW"** will result in a $25 penalty charge to your account that will be processed without Insurance contribution.

✔ If your therapist is unable to see your child on the scheduled day and time, a text or phone call will be made to the contact number provided below. Typically this phone call is made greater than 24 hours before the appointment or at the earliest time your therapist is aware of the need to cancel an appointment. In the case of an emergency, every attempt will be made to contact you at the number provided below prior to the scheduled therapy time on the day of therapy.

✔ **Excessive cancellations resulting in <75% attendance over a 3 month time period may result in discharge.**

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Child's Name (please print):_____

Parent's Name (please print):_____

Contact Phone Number:: _____

Secondary Contact Name and Phone Number: _____

I agree to the above cancellation policy: (Parent's Signature)_____

Notice of Privacy Practices

Your Privacy Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. A government rule requires that you receive a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPPA for short. WE will ask you to sign a paper saying that you have been given this notice. Read this notice at any time to see how your health information can be used and who can see it.

As required by the privacy regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), this notice describes how health information about you (as a patient of this practice, Holy City Pediatric Therapy, LLC) may be used and disclosed and how you can get access to your health information carefully.

Our Commitment To Your Privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

Our clinic is Required by Law to Keep Your Health Information Safe. This information may include: notes from your doctor, teacher or other healthcare providers, your test results, your medical history, treatment notes and/or insurance information.

How Your Health Information May Be Used Or Shared. We may use or share your health information without your permission for:

- **Treatment-** We may share information with doctors and other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
- **Payment-** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information we may share information to:
- Get the insurance companies permission to begin treatment
- Get permission for more treatment
- Get paid for the treatment you receive
- **Health Care Operations-** We may use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your information to:
- See how well our services are working
- See how well our staff is doing
- See how we compare to other clinics
- Make our services better

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- Help others study health care services

Your Health Information May Also Be Used Or Shared Without Your Permission For:

- **Abuse and Neglect**: We may share your information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders:** We may use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by email, by text, by phone call, or voice message. If you do not wish to get reminders please tell your speech-language pathologist.
- **As Required By Law:** We will share your information when we are told to do so by federal, state, or local law. we will also share information if we are asked by the police or courts.
- **Government Functions:** Your information may be shared for national security or military purposes. if you are a veteran, you information may be shared with the Office of Veterans Affairs.
- **Information About a Person Who Has Died:** We may share information with the coroner , medical examiner, or a funeral director as needed.
- **Marketing:** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks:** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration to report diseases and infections.
- **Regulatory Oversight:** We may use of share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure, and inspection.
- **Research:** We may share your health information with researchers to be included in their research project. Information will only be shared for projects that have passed a special approval process. These projects have rules to protect your privacy, too.
- **Threats to Health and Safety:** Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others
- **Workers Compensation:** We will share your information with Workers Compensation if your case is being considered as a work-related injury or illness.

When Your Permission Is Needed To Use or Share Your Health Information

You must give us permission to use of share your health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights. You have the right to:

- **Ask us not to share your information.** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family member or friends. you must ask for limits in writing. you must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call but not email. Or you may want us to call at work but not at home. You must ask us in writing. We will do all we can do as you ask.
- **Look at and copy your health information.** You have the right to see your health information and get a copy of that information. You have the right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes for your health information.** You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared.** You can ask us to tell you when and with whom your information was shared. There are some rules about this: you need to ask us in writing; you must tell us the dates you are asking about and if you want a paper or electronic copy; you may get information going back 6 years but it cannot be for earlier then April 14th, 2013. This is the date that the government privacy rules took effect.
- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.
- **File complaints.** You can file a complaint with us or with the government if you think that: your information was used or shared in a way that was not allowed; you were not allowed to look at or copy your information; any of your rights were denied.

Who is Covered by this Notice-The people that must follow the rules in this notice are:

- All Speech-Language Pathologists, assistants, and Audiologists working at this clinic
- Anyone who is allowed to add health information to your follow, including students and other staff
- Any volunteers that may help you when you are at this clinic

Changes to the Information in this Notice

We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we have did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints go to www.hhs.gov/our/privacy/hipaa/complaints/index.html. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have had any questions about this notice or your privacy rights, please ask your Speech- Language Pathologist.

Acknowledgement That You Have Received Our Privacy Notice

Office Phone: 843-696-2174
Office Fax: 888-659-8008
Office Address: 142 Sportsman Island Drive Suite E Charleston, SC 29492

Our clinic is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how to access and request changes to your information.

By signing this page, you agree that you have been given a copy of our privacy notice.

Signature:_____Date:_____

Witness:_____ Date:_____

holy city pediatric therapy

Peer Participation Consent Form

Patient's Name: _____ Patient's D.O.B:_____

Holy City Pediatric Therapy follows the Center for Disease Control's COVID-19 guidelines, which recommends the practice of social distancing and wearing face-coverings. At Holy City Pediatric Therapy adults are required to wear face-coverings at all times and highly encourages children to wear a face-covering while present for therapy services.

We understand that many of our clients acquire and refine therapeutic skills when interacting with their peers. In consideration of the current COVID-19 pandemic, you have the right to choose if you would like your child to participate socially with peers during your child's therapy session. Please state below if you would like your child to participate in peer play during their individualized treatment session.

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I, _____**(Caregivers Name)** consent to the following for my child's plan of care with Holy City Pediatric Therapy.

_____ **YES!** I give permission for my child to participate in play with peers at Holy City Pediatric Therapy for social interaction during treatment sessions.

_____ **NO!** I do not give permission for my child to participate in social interaction with peers at Holy City Pediatric Therapy.

Signature:_____**Date:**_____

Witness:_____ **Date:**_____

holy city pediatric therapy

Facility Dog

Griffon is a facility dog from Canine Companions for Independence who will be working with his trained and ADI certified handlers, Dusty and Kellye Tolley. Facility dogs are expertly trained to partner with a handler working in a professional setting. Canine Companions facility dogs are trustworthy in professional environments and can perform over 40 commands designed to motivate and inspire clients with special needs. Griffon, Dusty and Kellye have passed a nationally standardized practical test administered by an Assistive Dogs International certified evaluator.

Griffon is a 3 year old Labrador/Golden Retriever cross. He was carefully bred and expertly trained by Canine Companions specifically for this type of work; so, he is not only friendly and fun, he is also very sweet and gentle. His wonderful puppy raisers in Jacksonville, FL allowed him to have many opportunities with children and he excelled in playfulness, gentleness, and love with each situation. Griffon was provided to Holy City Pediatric Therapy, LLC by Canine Companions free of charge thanks to caring donations. We are thrilled to add him to our Therapy Team!

Below are some guidelines required for all Holy City Pediatric Therapy employees, clients and caregivers interacting with Griffon:

Caregivers are required to give written consent prior to participation in play with Griffon

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