Shining Star Therapy Services
613 Cook Street
Royston, GA 30662
Phone: (706) 491-5409
Fax: (888) 234-6659

Patient Information

Patient Name: ____________________________Gender: male female DOB: _______________

Address: ____

Parent/Guardian 1 Name: ____________________ DOB: _____________ SS#: ___________

Cell #:_________________ Home#:________________ Work #: _____________________

Employer: ____________________________Email: _______________________________

Parent/Guardian 2 Name: ____________________ DOB: _____________ SS#: ___________

Cell #:___________________ Home#:_________________ Work #: _________________

Employer: _______________________________Email: _____________________________

Primary Care Physician

Name of Practice or Doctor: ____

Phone #: __________________________ Fax #:___________________________________

Address: ____

Diagnosis or reason for referral: ____

Primary Insurance

Patient Name: _______________________________ DOB: ___________________________

Insured Name: ____________________ Relationship: _________________ DOB: ________

Insurance Company: ____

Customer Service/Provider # ____

Claims Address: ____

Member/Subscriber ID # _____________________ Group/Account #: ___________________

☐ I DO NOT HAVE INSURANCE OR I DO NOT WISH TO BILL MY INSURANCE FOR SERVICES RENDERED. I UNDERSTAND THAT SHINING STAR THERAPY SERVICES, LLC REQUIRES THAT ALL PAYMENTS FOR SERVICES RENDERED MUST BE PAID IN FULL AT THE TIME OF SERVICE. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY SHINING STAR THERAPY SERVICES, LLC OF ANY CHANGES.

Consent for Services

□ I authorize Shining Star Therapy Services, LLC to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Shining Star Therapy Services, LLC in writing. In addition, Shining Star Therapy Services, LLC may terminate services by notifying me in writing.

□ I do not give my consent or am withdrawing my consent regarding Shining Star Therapy Services, LLC rendering evaluation and therapy services to the client named below.

______________________________	______________________
Print Name of Client	Date
______________________________	
Client Date of Birth	
______________________________	______________________
Signature of Client or Legal Representative	Relationship to Client

Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While **Shining Star Therapy Services, LLC** understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 4 hours prior to your scheduled appointment.

□ A fee of **$25** may be assessed if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.

- If cancellations are made less than the required 4 hours.
- If the client fails to show up for a scheduled appointment.

□ If you **reschedule / are late for 4** scheduled appointments within **a six month period**, the office will reserve the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

□ If you fail to appear for an appointment **(no show)** without providing the appropriate advance notification for **3 or more appointments** within **a six month time period**, the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

□ I, __________________, understand the attendance / cancellation policy and the risks of not adhering to it.

______________________________	______________________
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______________________________	______________________
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APPOINTMENT REMINDERS

We can now send you appointment confirmation messages and reminders by text message or email. If you wish to receive these messages, we require your consent. Please read the disclaimer below then complete and sign.

I consent to Shining Star Therapy Services contacting me by text message/email for the purposes of appointment reminders.

I acknowledge that appointment reminders by text/email are an additional service and that these may not take place on all occasions, and **that the responsibility of attending appointments or cancelling them still rests with me (refer to attached attendance policy for more information)**.

Text messages are generated using a secure facility. I understand that they are transmitted over a public network onto a personal phone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified. I agree to advise the practice if my mobile number changes or if this is no longer in my possession. Also, I can cancel the messages at any time.

Child's Name: ....

Date of birth: ....

Mobile Number **or** Email (circle **one** and write below):

....

Signed: ....

Date ....

Background Information

PCP (referring physician): ____

Other physicians and specialist who provide care to the patient: (list others on back of page)

Name ______________________ Specialty _________________________

Name ______________________ Specialty _________________________

Patient lives with (check one): □ Birth Parents □ Adoptive Parents □ Foster Parents □ One Parent □ One Parent and Step-Parent □ Other ______________

Language other than English spoken at home? □ Yes □ No If yes, what? ________

Does the patient speak the language? □ Yes □ No

Does the patient understand the language? □ Yes □ No

Who speaks the language? ____

Which language does the patient prefer to speak at home? ____________

Please list the name, age and relation of those (other than parents) living in the patient's home.

NAME	AGE	RELATIONSHIP

Please list any of the patient's **relatives** having any of the conditions listed below: (e.g. Hearing Loss/Grandfather)

Mental/Intellectual Disability ___________ Autism/PDD _______________

Developmental Delay ____________ Speech/Language Delay ___________

Cleft Lip/Palate ________________ Reading Difficulty ______________

Other Birth Defect ________________ Learning Disability _____________

Hearing Loss _________________ Attention Deficits _______________

Other (specify) ____

What do you see as your child's most difficult problem? ___________________

Does your child currently have a diagnosis? □ Yes □ No If yes, what is it? _______

Does your child attend a school or daycare? □ Yes □ No

If yes, where and current grade level? ______________________________________

Does your child have an Individualized Education Plan (IEP)? □ Yes** □ No

If yes, what special services is your child receiving (speech, OT, PT, etc.)? ________

Does your child receive services through Babies Can't Wait? ☐ Yes** ☐ No

If yes, we will need a copy of the patient's most current IEP/IFSP.

Birth History

Pregnancy: ☐ Full Term ☐ Premature (_____ weeks) Birth Weight: ____________________

Illnesses or accidents during pregnancy? ____

Use of alcohol, tobacco, or medications during pregnancy? ___________________________

Delivery: ☐ Vaginal ☐ C-section ☐ Breech ☐ Feet First ☐ Forceps/Suction

Other unusual conditions that may have affected pregnancy or birth? ________________

____

Did your child pass the infant hearing screening? ☐ Yes ☐ No

Medical History

Has your child had any of the following?

☐ Adenoidectomy ☐ Ear Tubes ☐ Sleeping Difficulties

☐ Allergies ☐ Encephalitis ☐ Surgery (specify below)

☐ Breathing difficulties ☐ Head Injury ☐ Thumb/finger sucking

☐ Breaths from mouth only ☐ Hearing Problems ☐ Tonsillectomy

☐ Colds ☐ High Fevers ☐ Tonsilitis

☐ Ear Infections ☐ Meningitis ☐ Vision Problems

How often? _____ ☐ Seizures

____

____

Are immunizations current? ☐ Yes ☐ No

Is your child currently under a physician's care? ☐ Yes ☐ No

If yes, why? ____

Please list any medications your child takes regularly:

____

Does your child have any food or medical allergies? ☐ Yes ☐ No

If yes, explain: ____

Has your child or do they currently receive any therapy services (OT, PT, ABA, etc.)

Type of Therapy	**Frequency of Visits**	**Dates of Services**	**Location**	**Treating Clinician**

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ crawled _____ sat up (no assistance) _____ stood alone _____ walked

_____ drink open cup _____ drink with straw _____ fed self (fingers)

_____ fed self (spoon/fork) _____ dressed self

_____ toilet trained _____ single words _____ combined words

Does your child show unusual behavior (explain)? ___________________________________

Does your child… (check all that apply)

☐ Not eat enough variety ☐ Only eat crunchy solids ☐ Vomit during/after meals

☐ Poor growth/weight gain ☐ Aspiration (choking) ☐ Only eats purees

☐ Gagging ☐ Frequent diarrhea ☐ Only drink fluids

☐ Avoids whole food groups ☐ Frequent constipation

☐ Transitioning from tube to oral feeding ☐ Food refusal

☐ Not eating enough volume ☐ Tooth brushing intolerance

Favorite Foods: ____

Aversion Foods (if any): ____

Language Development

In which of the following areas does your child seem to have trouble? Check all that apply.

☐ Hearing Sounds ☐ Learning and using new words ☐ Stuttering

☐ Understanding what others say ☐ Using sentences

☐ Reading/writing

☐ Saying speech sounds ☐ Voice difficulties ☐ Other (please describe)

____

How many words are in your child's expressive vocabulary?

☐ 0-5 ☐ 10-20 ☐ 25-50 ☐ 50+

Is your child difficult to understand (check all that apply)?

☐ to you ☐ to family members ☐ to unfamiliar listeners

How long are your child's sentences? ____

Does your child have any difficulty understanding you (describe)?

____

Does your child have difficulty following directions (describe)?

____

Is your child aware/concerned/frustrated? ____

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.
We may create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information. The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.
This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.
Please contact the following for more information:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Shining Star Therapy Services, LLC is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- 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 maybe used and shared.

□ I acknowledge that I have received a copy of **Shining Star Therapy Services, LLC** HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

□ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

□ I understand **Shining Star Therapy Services, LLC** cannot disclose my health information other than as specified in the notice.

□ I understand that **Shining Star Therapy Services, LLC** reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_______________________________	______________________
Print Name of Client	Date
_______________________________	______________________
Signature of Client or Legal Representative	Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.

HIPAA Privacy Notice Acknowledgement

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: ________________________________

_________________________	_____________
Staff Member Signature	Date