Dear Family,

Welcome to the Edlantis Achievement Center! Thank you for scheduling an evaluation with us! The following information is important to read prior to your appointment.

1. We require a prescription for occupational and/or physical therapy from your pediatrician or specialty doctor (i.e., Developmental Pediatrician, Neurologist, Psychiatrist). A diagnosis code must be included. Please keep the original for your own insurance purposes, then fax, mail, or bring a copy of the prescription with you to your appointment.
2. Please make sure you complete the intake packet prior to your scheduled appointment. See checklist for details.
3. Your child's evaluation should take about 1 to 2-½ hours, depending on your child's age and the amount of standardized testing needed. In most cases, parents are asked to "sit in" with us, so that you can observe and your child will feel more comfortable.
4. We evaluate babies in their diapers. For toddlers or older children, we ask that you bring gym shorts, a bathing suit, or a leotard.
5. You may bring a small snack if you think your child might need one, during or at the conclusion of their evaluation.
6. All of our therapists are experts in handling children; so much of the process involves toys and fun equipment. Most children thoroughly enjoy themselves.

We look forward to meeting with you and your child. Please give us a call at 717-496-9364 if you have any questions.

Sincerely,

Joel Desotelle, MS OTR/L
Pediatric Occupational Therapist
Edlantis Achievement Center

New Patient Checklist

This checklist includes all of the information you will need to complete prior to your child's start of therapy. Please read, fill-out, and sign where indicated. This information helps to determine your child's benefits, area(s) of need, evaluation tools that will be administered, and covers important clinic policies. Please make copies for your own records.

Completed packets can be:

Mailed to:

Edlantis Achievement Center
450 Cleveland Ave., Suite D
Chambersburg, PA 17201

Faxed to: 1-888-567-1329

Checklist (please complete and read all documents):

- ☐ **Patient History Questionnaire**
- ☐ **About Your Child**
- ☐ **Admission Form**
- ☐ **Medical Release Form**
- ☐ **Medical Records Request Form**
- ☐ **Assignment of Benefits**
- ☐ **Consent to Treatment**
- ☐ **Financial Responsibility Agreement**
- ☐ **Attendance Policy**
- ☐ **EAC Clinic Policies**
- ☐ **Acknowledgement of Receipt of Notice of Privacy Practices**
- ☐ **Notice of Privacy Practices**
- ☐ **Food Permission/Dietary Information**
- ☐ **Videotape/Picture Release**

PATIENT HISTORY QUESTIONNAIRE

Patient Name:____**Age/DOB:**____________________

Parents'/Guardians' Names:____

Family Information:

Language(s) spoken in the home:____

Names and ages of siblings:____

Names and types of pets:____

Home situation (parents married/divorced?): ____

Child lives with: ____

List Current Concerns/Problem Areas:____

____

____

Patient/Care-Giver Goals (In your own words, what would you like to achieve in therapy).

____

____

Medical History

List any significant Medical History *(chronic ear infections/ tubes/ reflux/ surgeries, illness, hospitalization, etc...):*

___Chronic ear infections	___Seizures
___Tubes	___Vision deficits
___Tonsils/Adenoid Surgery	___Hearing problems
___Reflux	___Torticollis
___Surgeries: list above	___Frequent antibiotic use
___Poor sleep	___Frequent fevers
___Colic	___Compromised immune system
___Asthma	___Abnormal Lab results
___Allergies	___Cardiac Issues
___Abnormal muscle tone	___Lyme Disease
___Hear defect	___Poor weight gain
___Physical injuries	___Other:
___Meningitis	___Other:

Additional Diagnosis: Please indicate any medical diagnosis or medical condition below:

____

____

Hospitalizations, Surgeries, & Diagnostic Testing (please list)

____

____

Allergies/Reactions (food, latex, medication, other - please list):

____

____

Medication: Please include prescription drugs, over the counter medication, vitamins, and homeopathic medications.

Medication: ______________________________ Purpose: ____________________________

Medication: ______________________________ Purpose: ____________________________

Medication: ______________________________ Purpose: ____________________________

Medication: ______________________________ Purpose: ____________________________

Medication: ______________________________ Purpose: ____________________________

Medication: ______________________________ Purpose: ____________________________

Precautions/Contraindications: ____

____

____

Equipment/orthotics: ____

Birth History:

___Full Term ___Premature _______ wks Birth Weight: ________________

___Vaginal Delivery ___Caesarean Delivery

How long was your child in the hospital following his/her birth? ______________________________

Please describe any complications with the pregnancy or delivery: ____________________________

____

____

Developmental History: Please list in months when the following first occurred:

Held up head: ____________________________ Crawl ________________________________
Rolling tummy to back: ____________________ Rolling back to tummy: ____________________
Sitting without support: ___________________ Walking: _______________________________
Smile: __________________________________ First Words: ___________________________
Finger Foods: ____________________________ Use a spoon: ___________________________
Dress Self: ______________________________ Potty Trained:__________________________

Hand Dominance: ___Right ___Left ___Not sure

Other Therapeutic Services:
Occupational Therapist: ______________________________ School/Clinic: ____________________
Physical Therapist: ______________________________ School/Clinic: ____________________
Speech Therapist: ______________________________ School/Clinic: ____________________

Other Services:
Please list any other professionals and agencies who are currently seeing or have seen your child:
Case Worker & Phone #: ____
Early Intervention: ____
Neurologist: ____
Gastroenterologist: ____
Ear, Nose, Throat (ENT): ____
Other Specialist Physician: ____
Mental Health/Behaviorist: ____
Audiologist: ____
Nutritionist/Dietician: ____
Public Health Nurse: ____
Other: ____

Please list any other information you would like your therapist(s) to know: ____________________

____

Academic/ Educational History

___School/Pre-School: ____ Grade: ___________
___Is not enrolled in school/pre-school

My child... (*Fill in the blanks and check appropriate boxes that describe your child)*

___Does well in school: ____
___Does well with the exception of: ____
___Is challenged by school: ____
___Is challenged by writing: ____
___Is challenged by reading: ____
___Receives resource/ tutoring for: ____
___Receives classroom support for: ____
___Is an A B C D F Student
___Is in a self-contained classroom

List any academic/school concerns: ____

____

List specific teacher concerns: ____

____

About Your Child:

Every child is uniquely different. In order to understand your child and his/her present abilities, it is helpful to learn about your child in order to provide the most comprehensive assessment and treatment plan to meet his/her needs. Please complete the following and use additional paper if needed:

1. What kinds of things does your child enjoy? ____

____

2. What do you especially enjoy about your child? ____

____

3. **What major concerns do you have for your child? Why are you seeking occupational therapy?**

____

____

4. **Describe your child's gross motor skills (Can he walk, run, throw, catch a ball, ride a trike/bike with or without training wheels)?** ____

____

____

5. **Describe your child's fine motor skills (How does he manage a fork/spook/knife? Can he use a pencil/crayon? Can he use a scissors? How does he pick things up or manipulate objects?**

____

____

6. **Does your child need assistance with dressing? If so, how?** __________________________________

____

7. **Does your child need help with snaps, buttons, or zippers?** __________________________________

____

8. **Is your child able to tie his shoes?** ____

9. **Does your child need help taking a bath? Can he adjust the water temperature? Can he wash his hair and body thoroughly?**____

____

10. **Does your child need help brushing his teeth?** ____

11. **Does your child need help brushing his hair?** ____

12. **Is your child able to do simple chores around the house?** ___________________________________

____

13. **Does your child enjoy playing with other children or playing alone?** __________________________

____

14. **How does your child communicate with you and familiar people?** _____________________________

____

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Specializing In Pediatric Rehabilitation

15. Does your child do better with routine? What happens if the routine is altered?

____

____

16. **How does your child sleep? Does he sleep through the night? Do you have a bedtime routine? Does your child have difficulty getting to sleep? Does your child have difficulty getting up in the morning?** ______________________________________

____

____

17. **How well does your child do in the community (stores, mall, restaurants, offices, etc.)? Does he tolerate the activity around him?** ______________________________

____

____

18. **Describe your child's attention span. Can he work for long periods? Does he need supervision and assistance to get tasks done? How does he do with preferred tasks versus non-preferred tasks? What is the maximum he can sit and do an activity and what is his average attention span?**

____

____

____

____

19. **How does your child do with transitions? For example, leaving the park, getting into the car to go to the store, putting toys away for dinner.** ___________________________

____

____

20. What are your child's strengths? ______________________________________

____

____

21. What area(s) does your child need to improve? ____________________________

____

____

22. From when your child gets up to when he goes to bed, describe a typical day. Use additional paper if necessary. Please be as-specific-as-possible.

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Sensory History

My child... (*Check appropriate boxes that describe your child*)

___Is sensitive to sound
___Is sensitive to light
___Is distracted by busy environments
___Avoids crowds
___Gets upset or withdraws from loud noises
___Fixates on spinning objects
___Fixates on shiny objects
___Avoids touching objects or textures
___Is sensitive to clothing tags
___Is sensitive to seams in clothing or socks
___Avoids a certain texture food (crunchy, mushy, mixed, chewy)
___Quickly escalates without apparent cause
___Extremely sensitive to criticism
___Unable to self-calm
___Poor coping skills
___Is very busy and active
___Has difficulty paying attention
___Has difficulty listening
___Has difficulty following directions
___Prefers to play alone
___Has difficulty with transitions
___Is ritualistic with play
___Does not like crowds
___Does not like new places/ people
___Avoids a certain taste (salty, sweet, sour, spicy, bland)
___Is a picky eater
___Avoids certain smells
___Avoids heights
___Avoids movement activities
___Avoids playground equipment
___Avoids slides
___Avoids swings
___Is clumsy
___Gets dizzy easily
___Has poor balance
___Has poor sense of body and self
___Enjoys the playground
___Enjoys rough and tumble play
___Is a good eater
___Enjoys a variety of textured foods
___Overstuffs when eating and/ or pockets foods
___Seeks out excessive movement throughout the day
___Can't sit still
___Difficulty regulating states of arousal/ activity level
___Doesn't seem to register pain
___Doesn't seem to notice temperature extremes
___Enjoys a variety of textures play activities
___Likes to play in the bath
___Enjoys swimming or water play
___Likes messy play
___Likes to play with his/ her food
___Eats sticky/messy food with fingers (French toast sticks with syrup, French fries with ketchup, peanut butter and jelly, etc...)

Behavior/ Social History

My child... (*Check appropriate boxes that describe your child*)
___Is social and engaging
___Makes good eye contact with adults and peers
___Is well behaved
___Pays attention
___Listens well
___Follows directions well
___Plays well with other children
___Is easy going
___Does well with change
___Understands safety
___Takes turns with peers
___Is aggressive
___Is oppositional
___Has tantrums

List any behavior/ social concerns:

____

____

Any other comments about your child:

____

____

____

ADMISSIONS FORM

PATIENT INFORMATION:

Patient Name:_________________________________ Sex:_______ DOB/age:___________________

Patient Address: ____
____
____
____

Patient Phone: (_____) _______________________

PARENT/GUARDIAN INFORMATION:	**PARENT/GUARDIAN INFORMATION:**
Name: ______________________________	Name: ______________________________
Relationship to patient: __________________	Relationship to patient: __________________
Address: _____________________________	Address: _____________________________
_____________________________	_____________________________
_____________________________	_____________________________
Home Phone: (____) ____________________	Home Phone: (____) ____________________
Cell Phone: (____) ______________________	Cell Phone: (____) ______________________
Work Phone:(_____) ______________________	Work Phone:(_____) ______________________
Email Address: _________________________	Email Address: _________________________

INSURANCE INFORMATION:

Insurance #1: ________________________________
Policy Number: ______________________________ Group Number: _________________________
Insured: _____________________________________ Relation to Pt: _______________________
Insured's SSN:_________________________________ Insured's Date of Birth:___________________
Insured's address, if different from above:
____
____

Insurance #2: ________________________________
Policy Number: ______________________________ Group Number: _________________________
Insured: _____________________________________ Relation to Pt: _______________________
Insured's SSN:_________________________________ Insured's Date of Birth:___________________
Insured's address, if different from above:
____
____

PCP INFORMATION:

Name: ______________________________________
Address: ____________________________________
____
____
____
Phone: (_____) _______________________________
Fax: (_____) _________________________________

I certify that this information is true and correct to the best of my knowledge. I will notify Edlantis Achievement Center of any changes in the above information within 30 days.

Signature: _____________________________________ **Date:** _________________________

Name: ______________________

DOB: ______________________

Medical Records Release

I hereby authorize the Edlantis Achievement Center, Inc. to release patient therapy report and other pertinent information upon request to:

Name: ____
Address: ____
____
Phone: ___________________________

Name: ____
Address: ____
____
Phone: ___________________________

Name: ____
Address: ____
____
Phone: ___________________________

*Print additional copies of this form as needed.

This authorization is subject to my written cancellation at any time:

__________________________________ __________________________
Signature of Parent/Guardian Date

__________________________________ __________________________
Witness Date

MEDICAL RECORDS REQUEST FORM

RE: ______________________

DOB: ______________________

I hereby authorize *the Edlantis Achievement Center* to request patient information from:

Name: ____

Address: ____

____
Zip Code

Telephone: _(______)______________________________

Information to be released:

____

____

____

This authorization is subject to my written cancellation at any time.

Signed ______________________________ ________________________ __________
Parent/Guardian Relationship Date

Therapist/Witness ____ Date: ____________

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Assignment of Benefits

I authorize release of medical information necessary for billing purposes and assign the payment of medical benefits for (Child's Name) ___________________________ be made directly to the therapist(s) for services rendered.

I understand that I am responsible for any balance in excess of the benefits provided by my policy. I understand that by signing this statement and accepting treatment I agree to abide by these terms. I understand that it is my responsibility to be aware of pre-certification requirements and limitations of providers.

Signed _________________________________ __________________________ __________
Responsible Parties Signature Print Name Date

Witness ____ Date: ______________

Consent to Treatment

I authorize the Edlantis Achievement Center to provide medically necessary and beneficial specialty therapy services to my child (name) ________________________________. Furthermore, I understand that Edlantis Achievement Center has not promised any specific outcomes as to the services provided at this facility.

By signing this form, I have read, understand, and consent to treatment for my child named above:

Signed _______________________________ ________________________ __________
Parent/Guardian Relationship Date

Therapist/Witness ____ Date: _____________

*Edlantis Achievement Center reserves the right to make changes to this policy as appropriate.

Edlantis Achievement Center
Specializing In Pediatric Rehabilitation

Financial Responsibility Agreement

Our goal is to provide and maintain a healthy patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. **Please read this carefully** and if you have any questions, please do not hesitate to ask a member of our staff.

- I understand that Edlantis Achievement Center will submit my insurance claims on my behalf. I authorize my insurance company(ies) to pay directly to Edlantis Achievement Center all benefits due under the policy(ies) for services rendered. I agree that, if for any reason, my insurance company(ies) fails to reimburse any portion of a claim for services rendered at the Edlantis Achievement Center, it is my responsibility to pay what is owed in full.
- I understand that co-payments are due in full at the time services are rendered.
- Out-of-Network: I understand that Edlantis Achievement Center does not participate in all insurance plans and it is my responsibility to reimburse what is owed to Edlantis Achievement Center for services rendered at this clinic.
- Private Pay: I understand that payment for privately paid services rendered are expected in full at the time of service. For services provided without available insurance benefits, a 20% discount will be given to all payments made in full at the time services are rendered. Discount DOES NOT apply to co-payments and patient responsible balances under a qualified insurance plan.
- I understand that patient deductible balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 30 days of your receipt of your bill.
- I understand that balances past due more than 90 days will be subject to collections. Should my account become delinquent and be referred to any third party for collection efforts, I agree to pay all reasonable attorney's fees, court fees, and collection expenses.
- Divorce: In the case of a divorce or separation, the party responsible for the account balance is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment costs, I understand that it is the authorizing parent's responsibility to collect from the other parent.
- Payment: I understand that if a payment plan is set up on my behalf, it is my responsibility for all payments to be made timely as agreed. Even if a balance remains after my child's therapy has concluded, I am responsibility to continue payments until the entire balance has been remitted.
- I understand it is my responsibility to know my child's insurance plan benefits**.** If it is not covered, I will be responsible for payment at the time of visit. Not all services provided by our office are covered by every plan. Any service determined to not be covered by my plan will be my responsibility.
- Cancellation Policy: I understand that Edlantis Achievement Center requires a 24-hour notice for canceling any appointments (see attendance policy details and exceptions). Any appointment cancelled in less than 24 hours or missed as a result of a "no-show" will be charged a $60.00 missed visit fee. I understand that missed visit fees are not covered by my insurance carrier(s) and are entirely my responsibility.
- I understand that I will be assessed a $35.00 return check fee for any returned checks.
- I understand that if I am having financial hardship, it is my responsibility to contact Edlantis Achievement Center to discuss payment options to avoid my account going into default.
- I understand that my child may be discharged as a result of non-payment for services.

It is our priority that services are rendered based on your child's need for services and NOT on ability to pay. If needed, we will work with you to establish a payment plan that will fit your budget, however, payment in full is expected under the terms of the agreement.

By signing this form, I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

Signed ___________________________________ ____________________________ ___________
Responsible Parties Signature Print Name Date

Witness ____ Date: _______________

Attendance Policy

Your child's attendance is critical to his or her success. Edlantis Achievement Center understands there are times when families need to cancel therapy appointments. We request that whenever possible, families provide at least 24 hours notice when therapy appointments must be cancelled. Please call the office as soon as you realize that your child will not be able to attend therapy. You may leave a message on voicemail 24 hours a day.

In order to allow us to meet the needs of all the children seen at EAC, we have attendance policies that, if violated, will require us to cancel all previously scheduled appointments. Some possible causes that may require this action include:

1. Missing 3 appointments with less than 24 hours notice in a 60 day period.
2. 4 or more cancellations for any reason in a 60 day period.
3. Arriving more than 15 minutes late for your child's appointment 3 or more times in a 60 day period.

These attendance issues will result in the following actions:

- Children with regularly scheduled appointments will be removed from any future scheduled times, and will be required to schedule therapy sessions on a weekly basis as appointments are available. This probationary period will last 4 weeks beginning with the date of the first call.
- After this period children may resume regular scheduling including scheduling appointments up to 4 weeks in advance.
- Any additional attendance issues may result in an increased probation/weekly scheduling period or the patient may be discharged from therapy services.

Edlantis Achievement Center reserves the right to discharge any patient from therapy due to attendance issues.

Excused Missed Appointments:
- Approved family emergency
- Sick Child (see illness policy)
- Approved family vacations or scheduled time off.

Scheduled Vacations or Time Off:

Edlantis Achievement Center understands there are times when families will be away on a planned vacation or scheduled time away for other reasons. Edlantis Achievement Center allows scheduled time off, however if your child is going to miss services for more than one week, Edlantis Achievement Center reserves the right to charge a $35.00 per session fee to hold your child's weekly time slot.

Edlantis Achievement Center requires two weeks notice of any extended family vacations or requested time off.

Scheduled Facility Closings:

Edlantis Achievement Center will be closed on the following Holidays:

- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving and Black Friday
- Week of Christmas (specific days will be posted)

Edlantis Achievement Center may be closed for inclement weather. We will make every attempt to make up your child's appointment as the schedule permits.

Scheduled Appointments:
Parents are expected to be on time their child's appointments. Children that arrive 15 or more minutes late for an appointment will be seen or rescheduled as appointments are available.

We value the importance of establishing and maintaining home programs for the children that receive therapy. Parental/guardian involvement is the key to success for the child. We request that you be available 10 minutes PRIOR to the end of your child's therapy so the staff may talk with you and educate you on any home programming needs. If you are unavailable 10 minutes prior to the end of the treatment session or arrive late to pick up your child, the staff will not be able to address your home program or questions as they have other children to see.

By signing this form, I have read, understand, and agree to abide by the above attendance policy:

Signed ______________________________ ________________________ __________
Parent/Guardian Relationship Date

Therapist/Witness ____ Date: _____________

*Edlantis Achievement Center reserves the right to make changes to this policy as appropriate.

Edlantis Achievement Center Clinic Policies

What to Wear:
Your child should wear loose, comfortable clothing to each therapy session. Proper footwear and appropriate dress is important to allow freedom of movement, which will enable your child to participate fully. Sneakers are the preferable footwear; shorts or sweat pants are preferable - please no dresses or tight jeans (shorts may be worn under a dress if needed).

Please also make certain that your child is wearing or brings any appropriate vision and hearing assistance (such as glasses and hearing aids) that will enable them to fully participate in and benefit from therapy. Please avoid allowing your child to wear jewelry or bring valuable items such as gaming systems, which could be easily misplaced. Edlantis Achievement Center is not responsible for lost or stolen property.

Illness:
We do recognize that children at times are ill and cannot attend their scheduled sessions. Please do not bring your child, or a sibling, if they are ill; he/she will not benefit from therapy, and it places other children and their families at risk. If the patient or anyone accompanying them to their appointment presents with the following symptoms, please call our office as soon as possible to cancel:

- Fever within the past 24 hours
- Unexplained rash
- Intestinal symptoms such as vomiting or diarrhea
- Contagious illnesses such as chicken pox or conjunctivitis (pink eye)
- Your child was too ill to attend school on the day of the therapy appointment

Facility Delays and Closings:
The Edlantis Achievement Center is committed to the safety ad well-being of our patients and their families. In the event of inclement weather, we encourage you to verify the facility's hours of operation prior to traveling to your child's appointment by calling the center at 717-496-9364. Do not assume that the clinic is closed just because school has been cancelled.

In the event that the clinic has been closed, please contact us at 717-496-9364 to reschedule your child's appointment. We will make every effort to reschedule, however, rescheduled appointments are not guaranteed.

Facility Equipment:
The Edlantis Achievement Center offers a wide variety of specialized equipment and toys, which are therapeutic in design, to maximize your child's progress. This equipment requires one-on-one therapist assistance and supervision for safety. Patients' family members and friends are not permitted to use facility equipment or play with toys or games in the gym area unless specifically invited by the therapist to participate in the therapy session. Additionally, due to infection control requirements, therapy toys are reserved for patients only, and only with the supervision of the therapist.

Supervision:
The safety of our patient, your child, is our primary concern. Therefore, please note that all children, including patients, must have a parent or another adult caregiver present at the clinic at all times during treatment. Siblings must be closely supervised to insure their own safety. Edlantis Achievement Center is not responsible for injury for any misuse of the therapy equipment, activities, and/or non-compliance that may result from unsupervised children.

Siblings:
We encourage you to attend and actively participate in your child's therapy, as home programs are an integral part of therapy and essential for your child's progress. However, other children in attendance may interfere with the patient's progress. The safety of your child receiving therapy is our primary concern. Please make appropriate child care arrangements for siblings. If, however, siblings or other children must accompany you to

the patient's appointment, it is preferred that they wait in the waiting room; additionally, they must be supervised at all times by a responsible adult. Under certain circumstances, siblings may be allowed to accompany the patient into the treatment room. However, they are not permitted to wander about in the gymnasium; in addition, they may not use any of the equipment or play with toys due to the potential for injury as well as infection control policies.

Injuries:
While patient safety is our primary concern, the use of therapeutic equipment does involve inherent risks. While every effort will be made to secure your child's safety and minimize the risk of injury, in the event an injury does occur, Edlantis Achievement Center will not be held liable for any injury and/or medical costs related to the injury. Edlantis Achievement Center will provide basic first aid services upon request within the scope of the staff available, or will otherwise contact 911 and/or notify the child's physician as appropriate.

Child Abuse:
If Edlantis Achievement Center knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, the law requires such knowledge or suspicion to be reported to the proper authorities.

Judicial or Administrative Proceedings:
If you are involved in court proceedings, and a request is made for information about your child's diagnosis or treatment records, such information is privileged under state law and will not be released without the written authorization of you or your legal representative. The privilege does not apply where the evaluation is court ordered.

Cellphone Policy:
We require that cell phones and other two-way devices be turned off during sessions, whether you are directly observing in the treatment room or from the observation rooms.

Pet Policy:
Pets are not permitted inside the Edlantis Achievement Center unless the animal functions as a Service Animal. Patients and visitors are expected to adhere to the guidelines of this policy.

Smoking Policy:
Smoking is NOT permitted on the premises. Smoking is permitted only in your vehicles or off the premises. No exceptions.

Patient/parent Responsibilities:
For therapy to be effective, a partnership between the parent/guardian, child, and therapist is essential to achieve success. You are responsible to:

- Provide information about your child.
- Cooperate with recommendations, strategies, home programs, and attendance.
- Provide feedback and communicate about progress, changes in condition, and strategies that may benefit the child.
- Be considerate of all other patients, their families, and EAC staff at all times.

Edlantis Achievement Center cannot be held responsible for the outcome if you refuse treatment for your child, or do not follow the therapist's instructions.

By signing this form, I have read, understand, and agree to abide by the above EAC Clinic policies:

Signed ______________________________ ________________________ __________
Parent/Guardian Relationship Date

Therapist/Witness ____ Date: _____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of this office's Notice of
(Print Name)

Privacy Practices.

Signed ______________________________ ________________________ __________
Parent/Guardian Relationship Date

Therapist/Witness ____ Date: _____________

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communications barrier prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify):
____
____

Notice of Privacy Practices

This notice describes how health information about you or your child may be used and disclosed to coordinate health care and how you can get access to this information.
Please review it carefully.
The privacy of you or your child's health information is important to us.

Our Legal Duty
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. This Notice takes effect July 1, 2004, and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION
This Notice allows us to use health information about you or your minor child if you are a parent or guardian, as necessary, for coordinating treatment, payment, and healthcare operations. We will limit the release of information necessary to assist in the specific need. For example,

Treatment: Schedules will be posted in our operatories to assist in providing treatment. We may disclose health information to a physician or other healthcare provider treating you (or your child).

Payment: We may use and disclose your health information to obtain payment for services we provide you

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluations practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Persons Involved in Care: In the event of your incapacity, or in emergency circumstances, we will disclose health information based on a determination using our professional judgment that is directly relevant to the person's involvement of your best interest in allowing a person to pick up filled prescription, medical supplies, or other similar forms of health information.

Marketing Health-Related Services: We will not use your (or your child's) health information for marketing communications without your written authorization.

Abuse or Neglect: We may disclose your (or your child's) health information to appropriate authorities if we reasonably believe that you (or your child) are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your information to the extent necessary to avert a serious threat to your (or your child's) health or safety or the health and safety of others.

Contact Modes: We will use voicemail or answering machine messages, post cards, e-mails or letters if we cannot reach you personally. If we cannot speak to you directly, we will limit the information divulged as much as possible, except in matters of medical necessity.

PATIENT RIGHTS:
Access: You have the right to look at or get copies of your (or your child's) health information, with limited exceptions. We will use the format you request unless we cannot reasonably do so. (You must make a request in writing to obtain access to your (or your child's) health information) We will charge you a reasonable cost based fee for expenses such as copies and staff time.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your (or your child's) health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with your about your (or your child's) health information by alternative means or alternative locations. **(You must make your request in writing)** Your request must specify alternative means or location, and provide satisfactory explanation of how payments will be handled under alternative means or location which you request.

Amendment: You have the right to request that we amend your health information. (**Your request must be in writing and it must explain why the information should be amended)** We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS
If you would like more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or a t alternative locations, you may complain to us, or submit a written complaint to the US Department of Health Services. We will provide you with the address to file your complaint.

Food Permission/Dietary Information

Please list any allergies your child may have, including food, non-food, and/or latex:
____
____

Please complete the following to allow your child to participate in snack activities:

________ My child may participate in snacks and has no diet restrictions.
________ My child may participate in snacks if diet restrictions are observed. Diet Restrictions:
________ My child may participate in snacks; however, I will provide his/her snack.
________ My child should **not** participate in snack time. Please list the food(s) your child is motivated to eat:

Video and Picture Release

PERMISSION TO PHOTOGRAPH

I grant permission to the treating clinicians to record, photograph and/or videotape my child. I understand that the media can be used for several purposes including therapeutic purposes of evaluation, comparative studies to determine progress, training, and education, marketing and website. I agree to the following:

Therapeutic Purposes:	___Yes	___No
Education/Training Purposes:	___Yes	___No
Marketing Purposes:	___Yes	___ No
Facility Website:	___Yes	___No

Signed ______________________________ ________________________ __________
Parent/Guardian Relationship Date

Therapist/Witness ____ Date: _____________