Notice of Points of Stillness, LLC Privacy Practices

Points of Stillness, LLC is required to provide patients with this Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed as well as how you can obtain access to this information. Please review carefully.

Medical Information may be use for the following purposes by POINTS OF STILLNESS, LLC:

- Treatment: We will use the information to provide, coordinate and manage care and treatment. For example, we will release reports to another provider who is involved in you care.
- Payment: We will use information to receive payment for services we provide. For example, we will disclose information in order to submit bills or claims to insurance companies and /or Medicare or State funded plans.
- Health Care Operations: We will use information for certain activities related to business functions of Points of Stillness, LLC. For example, we may use or disclose information for quality assurance activities.
- Appointment Reminders and Other Health Information: Information may be used to provide you with information about new or alternative treatments or other health care services that may be of interest to you.
- Family Members or Other Responsible People: You may agree to have verbal information about your treatment shared with a family member or designee.
- Other Uses or Disclosures: Disclosures or use information in the following cases: when required by law; for public health activities; relating to victims of abuse/neglect/domestic violence; for health oversight activities; for judicial and administrative proceedings to the extent permitted by law; for law enforcement purposes, as permitted or required by law; to coroners/medical examiners/funeral directors, as permitted by law; for organ donation purposes; for research purposes under certain circumstances: to avert a serious threat to health or safety: for certain specialized government functions, such as military discharge and national security and intelligence; and for workers' compensation purposes.

Your individual Privacy Right as a patient includes the following:

- Restrict Use and Disclosure: You have the right to request that Points of Stillness, LLC not use your treatment information in certain ways or for certain purposes. You may also request that we not provide treatment information to certain individuals. However, Points of Stillness, LLC has the right to refuse you request, particularly when law requires it. In the case where emergency treatment is necessary, we will ask the person(s) who receive the information not to further use or disclose the information.
- Provide Confidentiality: You have the right to request that Points of Stillness, LLC provide you with your treatment information in a confidential manner. For example, you can request that we send bills and other mailings to a different address or that we notify you of this kind of information in another way, such as by telephone call. You must make this request in writing and specify another address or means of communication. Under certain circumstances, we may deny your request. We will agree to your request to the extent we are able to assure accuracy in doing so. Your request for such confidentiality may require that you provide us with information on how you will pay your bills.
- Research: Under certain circumstances we may use and disclose treatment information about you for research purposes. We will only do this with you written authorization, or with the approval of the special board that will insure that there is only a minimal risk to your privacy.
- Inspection and Copy: You have the right to ask to see and copy your treatment records, unless there is information protected by law. In our practice your treatment record is limited to reports and billing information. We may charge you fees associated with copying costs.
- Change Information or Amend Medical Records: You have the right to request in writing that we change information in your treatment record if we were the originator of such information. If you request is denied, you can write a statement of disagreement with the denial that we will keep with your treatment information.
- Accounting of Disclosure: You have the right to request an accounting of disclosures. This would include releasing treatment information about you, which was not related to treatment, payment, healthcare operations, or information you requested to release to another facility or persons. Requests for accountings will not include those made prior to May 1, 2010.
- Paper Copy of Points of Stillness, LLC Patient Notice of Privacy Practices: If you have received this notice of the treatment information privacy rights electronically, you may ask us to provide you with a paper copy.
- Privacy Violations: If you feel your treatment information privacy rights have been violated, you may file a complaint with the Secretary of Health and Humans Services and/or with Points of Stillness, LLC. Filing a complaint will not affect the quality of the services you receive from Points of Stillness, LLC and you will not be retaliated against for filing a complaint.

The U.S. Secretary of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free: 1-877-696-6775

The effective date of this notice is May 1, 2010. Points of Stillness, LLC reserves the right to change this notice and will make the new information available to you in person or by posting it in our office.

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

PEDIATRIC INTAKE

CLIENT INFORMATION: (Please Print)

Last Name: _____First Name: _____Middle Initial:_____

Street: _____

City: _____State:_____Zip:_____

Parent/Guardian Name: (if client is a minor) _____

Home Phone: ( ) -

Name_____ Cell Phone: ( )

Name_____ Cell Phone: ( )

Email: (please print) _____@_____

Client Date of Birth: ____/____/_____ Client Gender: (circle) Male / Female

Medical Insurance Company_____Group#_____ID#_____

Policy Holder of Medical Insurance: (check one) _____Self _____Spouse _____Parent _____Other

Policy Holder Date of Birth _____/_____/_____

Employer Name: _____ Employer Phone: _____

Physician Name: _____ Physician Phone:_____

Physician's Clinic Name and Address: _____

_____

Provide Insurance Card to Front Desk.

Would you like to sign up for the Points of Stillness newsletter? YES or NO

I have read, understand and agree to the Notice of Points of Stillness, LLC Privacy Practices.

_____ _____

Client Name Date

_____ _____

Parent/Guardian/Legal Representative Signature Relationship to Client

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

CLIENT AUTHORIZATION: **(Please Print)**

CLIENT LAST NAME: _____ FIRST: _____
CLIENT DATE OF BIRTH: _____/_____/_____

I authorize Points of Stillness, LLC to release to physicians currently involved in my care and to my insurance carriers, all health information, including reports related to my current reason for seeking service. I also authorize my referring or consulting physician and or other examination facility to release medical records to Points of Stillness, LLC.

I authorize payment of my insurance claims related to services I receive at Points of Stillness, LLC to be made directly to Points of Stillness, LLC. I understand this authorization is valid one year from date of signing.

I agree to be financially responsible for any charges not covered by my worker's compensation insurance, auto insurance, personal injury carrier, Medicare or my private health insurance carrier. If I have no insurance I understand I am financially responsible for all charges incurred. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Points of Stillness, LLC for any services I receive at Points of Stillness, LLC. I authorize any holder of hospital or medical information about me to release to CMS (Medicare) and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

PHOTO AND VIDEO RELEASE

_____ I authorize employees of Points of Stillness, LLC to photograph/videotape my child for the purpose of: in center clinical discussion and teaching, publications such as brochures and flyers, use on clinic website and Facebook page, presentations in workshops to other professionals or parents, and for RDI evaluation and treatment of Autism.

_____ I do NOT authorize photos/videotaping of my child.

This consent is valid for the full term of my child's therapy at Points of Stillness, LLC unless otherwise allowed by law. I understand I may revoke (cancel) this consent, in writing, at any time. Revoking consent does not apply to information that has already been disclosed.
My signature below means that I have read, understand and give my consent.

RELEASE OF INFORMATION

I authorize the release and receipt of information about this client's therapeutic treatment for the purpose of:
_____ Collaborating care with other caregivers or agencies providing services
_____ Legal proceedings
_____ Transfer of care
_____ Research (no name included)
The following professional's, caregivers and or agencies are authorized contacts:

_____

_____

_____

_____ _____
Client Name Date

_____ _____
Parent/Guardian/Legal Representative Signature Relationship to Client

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

CLIENT INTAKE: (Please Print)

CLIENT LAST NAME: _____ FIRST: _____

Diagnosis: _____

Accidents or Injuries (type and date)_____

_____

_____

Recent Illnesses _____

_____

_____

Current Medications _____

Allergies or Diet Restrictions _____

Physician Name _____Physician Phone _____

Physician's Clinic Name & Address _____

I authorize the following therapy (check all that apply)

_____ Occupational Therapy
_____ Acuscope
_____ Myopulse
_____ Craniosacral Therapy
_____ Auditory Integration/Therapeutic Listening Protocols
_____ Integrated Care
_____ Sensory Processing Intervention
_____ AcuEnergetics®
_____ Cold Laser

_____ _____
Client Name Date

_____ _____
Parent/Guardian/Legal Representative Signature Relationship to Client

CHILD OCCUPATIONAL THERAPY EVALUATION QUESTIONNARE: **(Please Print)**

CLIENT LAST NAME: _____ FIRST: _____

1. What specifically prompted you to seek an Occupational Therapy Evaluation for your child?

   _____

   _____

2. What are your primary concerns for your child at this time?

   _____

   _____

3. Has your child had Occupational Therapy in the past? Yes/No
   If so, where and when? _____

   _____

   Was your child discharged or was care discontinued and why? _____

   _____

4. Is your child currently or has previously been under the care of any other health professionals?

   _____ Psychologist When? _____Where? _____
   _____ Vision Therapist When? _____Where? _____
   _____ Physical Therapist When? _____Where? _____
   _____ Speech Therapist When? _____Where? _____
   _____ Chiropractor When? _____Where? _____
   _____ Other _____ When? _____Where? _____

5. Does your child have siblings? If so, what are their ages? _____

   _____

6. Does your child attend school and/or day care? Where? When? _____

   _____

7. Does your child receive any special services in their school program? Yes/No

   Do they have an IEP? Yes/No

   If so, do they receive Occupational Therapy as a part of their IEP? Yes/No
   If yes, how much time per week or per cycle? _____

   Is the therapy Direct or Indirect (consult with teacher)? _____

8. Are there any special precautions you would like us to be aware of? _____

   _____

9. What are your child's strengths? _____

   _____

   _____

   _____

10. What are your child's likes and interests? _____

    _____

    _____

    _____

11. Is there anything else you would like us to know about your child? _____

    _____

    _____

    _____

Thank you! This information helps us to best provide service to your child.