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 ensure 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.

PEDIATRIC OT INTAKE

CLIENT INFORMATION: (Please Print)

Client Last Name: _____**First Name:** _____**Middle Initial:** _____

Street/PO Box: _____ City: _____State:_____ Zip: _____

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

Parent/Guardian Name: _____ Single/Married/Divorced (circle one)

Street/PO Box: _____ City: _____State:_____ Zip: _____

Cell Phone: ( ) _____ **Email:** (please print) _____

If divorced, please provide a copy of any custody agreement.

Parent/Guardian Name: _____ Single/Married/Divorced (circle one)

Street/PO Box: _____ City: _____State:_____ Zip: _____

Cell Phone: ( ) _____ Email: (please print) _____

If divorced, please provide a copy of any custody agreement.

Primary Medical Insurance Company_____**Group#**_____**ID#**_____

Policy Holder Name _____Relationship to Client___Self__Parent__Other

Policy Holder Date of Birth _____/_____/_____

Secondary Medical Insurance Company_____**Group#**_____**ID#**_____

Policy Holder Name _____Relationship to Client___Self__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

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 my child for purpose of internal intake records.

_____ 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)

Please list authorized contacts & phone numbers (such as doctors, agencies, caregivers) below:

1) Functional Kids Phone: 651-770-8884
2) _____
3) _____
4) _____
5) _____
6) _____

_____ _____
Client Name Date

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

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)
We will consult with you before including any of the therapy programs below.

_____ 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.

Points of Stillness Attendance and Cancellation Policy

Points of Stillness strives to provide exceptional care and the highest quality of services possible for all clients. In order to do so, regular attendance is necessary to establish a positive treatment routine and to build and maintain skills. Inconsistent attendance hinders achievement of goals and prevents clients from receiving the full benefit from therapy. In order to encourage consistent attendance, Points of Stillness has established the following policy:

CANCELLATIONS: We understand that due to illness or other unexpected events it may be necessary for you to cancel a therapy appointment.

· Notice is expected prior to the appointment, and at least 24 hours' notice is requested.

· It is your responsibility to notify/call the front desk as soon as possible if you need to cancel a therapy appointment and provide a reason for the cancellation.

· Please notify the clinic at least two weeks prior to vacations or other planned obligations that will result in missing a scheduled treatment session. Please review our travel policy for additional information.

· Excessive cancellations (more than three appointments within two months) may result in the loss of the client's treatment spot, discussion about finding an alternate appointment time and/or placement on a waiting list. Extenuating circumstances will be taken into consideration.

NO-SHOWS: A no-show is defined as failure to give notice prior to missing an appointment and failure to attend the scheduled appointment.

· Two no shows may result in the loss of the client's treatment spot. Extenuating circumstances will be considered.

PUNCTUALITY: We ask that clients consistently arrive on time for all scheduled appointments in order to receive the optimal benefits from therapy.

· Please arrive no more than five minutes early for each session and notify the clinic if you are going to be arriving late.

· If your child is attending therapy, you are required to be here at least five minutes prior to the end of the scheduled session.

· Punctuality for appointments allows adequate therapist/patient interaction. This also gives us time to report outcomes to parents and disinfect therapy spaces.

· Frequent tardiness for drop off and/or pick up (more than 10 minutes late) may result in loss of the client's treatment spot.

High levels of cancellations or missed appointments may adversely affect therapy progress and success at therapy. We value your time and the time our therapists devote into preparing for and implementing each session. Consistent attendance helps honor the collaboration between clients and therapists and highlights the combined effort required to achieve therapeutic goals. Your signature below indicates your understanding of this policy and your commitment to receiving the full benefits of therapy.

Client Name: _____

Parent/Guardian Signature: _____ Date: _____

Sensorimotor History

Child's Name_____ Date of Birth_____Date_____

Please think of the various stages of your child's development, considering behavior that comes to mind as you answer these questions. What do you think of as being different from other children you know? Were there times when your child's behavior was difficult to cope with in the family unit?

The following questions are posed to help in compiling a more complete picture of your child from early infancy to present developmental stage. Some of the questions may refer to children who are older than you own. Kindly cross out the verb tense that does not apply. Check the choice that applies: Yes, No, Used to or N/A (not old enough, yet or for other reasons, not applicable). Add narrative information that would also be important on the back. Thank you for your assistance.

___Pregnancy/Delivery Details Unknown**(cont to next page)**

Did Mother…	YES	NO
1) Have any infections/illnesses during pregnancy? If yes, describe:		
2) Have any shocks or unusual stress during pregnancy? If yes, describe:		
3) Water break more than 24 hours before delivery?		
4) Develop toxemia/high blood pressure? When?		
5) Have any complications during delivery and/or labor?		
6) Was labor induced?		
7) Number of previous miscarriages?		
8) Mother's age at deliver?		
9) If premature, how early?		
10) If post mature, how late?		
11) What was the child's birth weight?		
12) Child's weight when discharged from the hospital?		
13) Apgar scores 1 minute _____ 5 minutes _____		

Child's Birth History

Was or did your child…	YES	NO
1) Cesarean Section		
2) Breech (feet first)		
3) Face presentation		
4) Transverse (sideways)		
5) Cord wrapped around neck		
6) Require forceps/vacuum extraction		
7) Have any birth injuries		
8) Require a fetal monitor		
9) Have insufficient oxygen		
10) Cry right away		
11) Require intensive care hospitalization		
a. How long		
b. Respiratory problems		
c. Need respirator How long?		
d. Small for age		
e. Heart defect		
f. Require transfusion		
g. Jaundiced How long under lights?		
h. Have any abnormalities Describe:		
i. Have seizures		
j. Have infection at birth		
k. Have surgery as newborn		
l. Have feeding problems as a newborn		

Tactile (Touch)

Does your child…	Yes	No	Used to	N/A
1) Like to be touched				
2) Dislike being held or cuddled				
3) Prefer to touch rather than be touched				
4) Seem excessively ticklish				
5) Seem easily irritated or enraged when touched by siblings or playmates				
6) Have a strong need to touch people and objects				
7) Seem to pick fights				
8) Pinch, bite or otherwise hurt self or others				
9) Frequently bump or push others				
10) Bang head on purpose				
11) Like to touch animals				
12) Dislike the feeling of certain clothing				
13) Over or under dress for the temperature				
14) Overheat easily				
15) Seem overly sensitive to food and water temperature				
16) Seem overly sensitive to rough food textures				
17) Prefer tub baths over showers				
18) Like to play in water, sand, mud, clay, etc.				
19) Seem to lack the normal awareness of being touched				
20) Often seem unaware of cuts, bruises, etc.				
21) Avoid using hands				
22) Examine objects or clothes with hands				
23) Mouth objects or clothes excessively				

Taste and Smell

Does (is) your child	Yes	No	Used to	N/A
1) Act like all food is the same				
2) Explore with taste				
3) Chew on non food items				
4) Have any feeding problems				
5) Trouble changing to textures				
6) Hypersensitive to smells				
7) Taste or smell toys, clothes, or foods more than usual				
8) Did your child breast feed How long?				
9) Did your child bottle feed How long?				
10) Use a pacifier, suck thumb How long?				
11) Have food allergies				
12) Have food sensitivities				
13) Require a special diet				
14) Eat a variety of foods				
15) Have food cravings				

Visual

Does (is) your child…	Yes	No	Used to	N/A
1) Have a visual problem				
2) Seem very sensitive to light				
3) Have trouble using eyes				
4) Avoid eye contact				
5) Distracted by visual input				
6) Dislike eyes covered				
7) Able to close eyes for short periods				
8) Make reversals when writing, copying or reading				
9) Avoid sunlight				
10) Have trouble with shapes, colors or size				
11) Squint often				
12) Able to look far away				
13) Able to look close				
14) Use 2 eyes together				
15) Look to side or down to see things close up				

Auditory (sound)

Does (is) your child…	Yes	No	Used to	N/A
1) Have a hearing loss				
2) Have (had) PE tubes				
3) Have (had) a lot of ear infections				
4) Hypersensitive to sounds				
5) Fear of unexpected noises				
6) Fear of unusual sounds				
7) Distracted by sound				
8) Miss sounds or words				
9) Have trouble listening				
10) Have trouble locating sound				
11) Make loud noises				
12) Sing/dance to music				
13) Have trouble imitating rhythmic sounds				
14) Have trouble understanding or following directions				
15) Cover ears to block sounds				
16) Talk excessively				
17) Talking interferes with listening				
18) Delayed speech development				

Vestibular/Proprioception
(Movement/Gravity/Muscle & Joint Activity)

Does your child…	Yes	No	Used to	N/A
1) Arch back when held or moved				
2) Enjoy being rocked				
3) Like being tossed in the air				
4) Like fast rides				
5) Like to swing				
6) Spin or whirl more than other children				
7) Get carsick easily				
8) Get nauseous and/or vomit from other kids of movement				
9) Rock/bounce while sitting				
10) Jump a lot				
11) Have fear in space (stairs, heights)				
12) Lose balance easily				
13) Walk on toes (not whole foot)				
14) Misunderstands meaning of words used in relation to movement or position				
15) Enjoy upside down play				
16) Like to jump from steps or heights				
17) Like to climb				
18) Like to push/pull heavy things				
19) Like to hang from door knobs, play equipment, woodwork				

Coordination

Does (did) your child…	Yes	No	Used to	N/A
1) Sit, stand or walk late				
2) Sit, stand or walk early				
3) Creeping or crawling phase omitted or short				
4) Creeping or crawling phase very long				
5) Movements slow, plodding deliberate				
6) Play with toys appropriately for age				
7) Trouble with dressing, buttoning, zipping or shoe tying				
8) Clumsy with toys				
9) Trouble holding pencil correctly				
10) Creep on tummy or bottom				
11) Trip or fall a lot				
12) Seem awkward				
13) Bump into things				
14) Definite hand preference Which?_____				
15) Poor handwriting				
16) Handle small things easily				
17) Eat neatly for age				
18) Have rigid movements				
19) Grimace or use tongue in fine motor tasks				
20) Shaky in fine motor tasks				
21) Like sports, phy ed				
22) Have many ideas of what and how to play				

Muscle Tone

Does your child…	Yes	No	Used to	N/A
1) Feel heavier than looks				
2) Have good endurance				
3) Have a muscle problem				
4) Have flat feet				
5) Slump when sitting				
6) Get tired easily				
7) Seem weak				
8) Keep mouth open				
9) Seem stiff				

Learning Styles

Does (did) your child…	Yes	No	Used to	N/A
1) Recognize own errors				
2) Learn from mistakes				
3) Acquire materials for task independently				
4) Able to set up work space				
5) Maintain work space				
6) Work independently				
7) Generalize known skills to new ones				
8) Age appropriate memory				
9) Ask for help when necessary				
10) Plan ahead				
11) Create new ideas, new ways of doing things				
12) Use age appropriate content in written language				
13) Get work done on time				
14) Average reading level				
15) Average math level				
16) See possibilities for exploration play in environment				
17) Use trial & error to proble solve				
18) Exhibit curiousity				

Behavior/Temperament

Is or was your child…	Yes	No	Used to	N/A
1) Quiet, calm, patient				
2) Active, outgoing				
3) Intense, anxious				
4) Explosive, aggressive				
5) High activity level				
6) Easy going, predictable				
7) Low activity level				
8) Erratic sleep patterns				
9) Irritable baby				
10) Clingy				
11) Rigid, set in ways				
12) Adaptable, flexible				
13) Regular sleep patterns				
14) Difficult to get to sleep				
15) Wake frequently				
16) Night terrors, nightmares				
17) Plays well alone				
18) Destructive with toys				
19) Short attention span				
20) Distractible				
21) Difficulty making choices				
22) Self stimulation behaviors				
23) Frequent tantrums				
24) Moody				
25) Difficulty with change				
26) Acts out				
27) Makes friends easily				
28) Prefer older children				
29) Prefer adults				
30) Prefer being alone				
31) Low self esteem				
32) Frustrated frequently				
33) Seem discouraged or depressed				
34) Express joy in play as much as other children				
35) Prefer repetitive activity				
36) Prefer novel activity				
37) A perfectionist				
38) Engage in creative play				
39) Need control in interactions and play				

Your child's primary sleep position in the 1st year:

Back_____Side_____Tummy_____

Any variations in the usual vaccinations schedule?

Yes____No____Explain_____

_____

NOTES:_____

_____

_____

_____

_____

Patti Oetter, MA, OTR, FAOTA 1986:revised, 2005 (adapted from A.J. Ayres, PhD; Patricia Wilbarger, Med, OTR, FAOTA; Montgomery/Richter, 1977; Knickerbocker, OTR and Jo Murphy Hyland, OTR)