POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

CLIENT INFORMATION:

Client Legal Last Name: _____First Name: _____Middle Initial: _____

Preferred Name: _____

Date of Birth: _____/_____/_____ Birth Sex: male/female (circle)

Cell Phone: _____ Home Phone: _____

Email: _____

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

Emergency Contact Name: _____ Cell Phone: _____

INSURANCE INFORMATION:

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: _____ Clinic Name: _____

PLEASE PROVIDE AN INSURANCE CARD AND VALID PHOTO ID TO FRONT DESK

I authorize the following therapy (check all that apply)

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

_____ Occupational Therapy _____ Speech/Language Therapy _____ Light Therapy/Cold Laser

_____ Acuscope/Avazzia _____ Myopulse _____ AcuEnergetics®

_____ Craniosacral Therapy _____ Auditory Integration/Therapeutic Listening Protocols

_____ Sensory Processing Intervention _____Kinesiotape _____ Brain Activating Breathing

_____ _____

Client Name Date

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 until services are discontinued

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 **(initial each that apply)**

_____ I authorize employees of Points of Stillness, LLC to photograph me for purpose of internal intake records.

_____ I authorize employees of Points of Stillness, LLC to photograph/videotape me 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, and for RDI evaluation and treatment of Autism.

_____ I do NOT authorize photos/videotaping of me.

This consent is valid for the full term of my 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 my 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 all authorized contacts, phone, & fax numbers (such as doctors, agencies, relatives, etc.) below:

Name:_____ Phone:_____ Fax:_____

Name:_____ Phone:_____ Fax:_____

Name:_____ Phone:_____ Fax:_____

_____ _____

Client Signature Date

CLIENT OCCUPATIONAL THERAPY EVALUATION QUESTIONNARE: (Please Print)

Please complete this entire questionnaire. It will provide your therapist with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

CLIENT LAST NAME: _____ FIRST: _____

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

   _____

   _____

2. What are your primary concerns at this time?

   _____

   _____

3. Have you had Occupational Therapy in the past? **Yes No**
   If yes, where and when? _____

   _____

   Were you discharged or was care discontinued and why? _____

   _____

4. Are you currently or have you 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? _____

Health History

Name: _____ DOB: _____

Marital Status: ___ Single ___Partnered ___Married ___Separated ___Divorced ___ Widowed

Number of Children: _____ How many live with you? _____

Occupation: _____ If retired, what was your occupation? _____

Childhood Illness: ___ Measles ___Mumps ___Rubella ___Chickenpox ___Rheumatic Fever ___ Polio
___ Other_____

Surgeries

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

___I have had no surgeries

Other hospitalizations

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

___I have never been hospitalized

Please indicate if YOU have a history of the following:

___ Alcohol Abuse
___ Anemia
___ Anesthetic Complication
___ Anxiety Disorder
___ Arthritis
___ Asthma
___ Autoimmune Problems
___ Birth Defects
___ Bladder Problems
___ Bleeding Disease
___ Blood Clots
___ Blood Transfusion(s)
___ Bowel Disease
___ Breast Cancer
___ Cervical Cancer
___ Colon Cancer
___ Depression
___ Diabetes
___ Growth/Development Disorder
___ Hearing Impairment
___ Heart Attack
___ Heart Disease
___ Heart Pain/Angina
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ High Blood Pressure
___ High Cholesterol
___ HIV
___ Hives
___ Kidney Disease
___ Liver Cancer
___ Liver Disease
___ Lung Cancer
___ Lung/Respiratory Disease
___ Mental Illness
___ Migraines
___ Osteoporosis
___ Prostate Cancer
___ Rectal Cancer
___ Reflux/GERD
___ Seizures/Convulsions
___ Severe Allergy
___ Sexually Transmitted Disease
___ Skin Cancer
___ Stroke/CVA of the Brain
___ Suicide Attempt
___ Thyroid Problems
___ Ulcer
___ Visual Impairment
___ Other(please list below)
___ NONE of the above list

List other past medical problems:_____

_____

_____

List your prescribed and over-the-counter drugs, such as vitamins and inhalers.

Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____
Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____
Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____
Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____
Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____

___ I take no medications, vitamins, herbals, or any other over-the-counter preparations.

Allergies:

Name _____ Reaction you had_____
Name _____ Reaction you had_____
Name _____ Reaction you had_____

Family Medical History

Please indicate if YOUR FAMILY has any history of the following: (only include parents, grandparents, siblings, and children)

___ I am adopted and do not know biological family history

___ Alcohol Abuse
___ Anemia
___ Anesthetic Complication
___ Arthritis
___ Asthma
___ Bladder Problems
___ Bleeding Disease
___ Breast Cancer
___ Colon Cancer
___ Depression
___ Diabetes
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Leukemia
___ Migraines
___ Osteoporosis
___ Other Cancer
___ Rectal Cancer
___ Seizures/Convulsions
___ Severe Allergy
___ Stroke/CVA of the Brain
___ Thyroid Problems
___ Mother, Grandmother, or Sister developed heart disease before the age of 55
___ Father, Grandfather, or Brother developed heart disease before the age of 55

List any other conditions or concerns with YOUR FAMILY medical history:

_____
_____
_____

Personal Safety

Do you live alone? **Yes** **No**
Do you have frequent falls? **Yes** **No**
Do you have vision or hearing loss? **Yes** **No** Please list: _____
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your therapist? **Yes** **No**

Trauma is defined as any event that is perceived as challenging or extremely stressful. It can be a physical event (i.e.: car accident) or emotional event (i.e.: loss of a loved one).
Trauma effects the body and the mind and can interfere with the body's healing.

Have you had physical trauma? **Yes No**
If so, please describe:_____

Have you had emotional trauma? **Yes No**
If so, please describe:_____

For Women Only

Number of pregnancies? _____
Number of live births? _____

Have you had a D&C, hysterectomy, or Cesarean?	**Yes No**
Are you currently pregnant?	**Yes No**
Are you currently breastfeeding?	**Yes No**
Any urinary tract, bladder, or kidney infections with the last year?	**Yes No**
Any problems with control of urinations?	**Yes No**

Mental Health

Is stress a major problem for you?	**Yes No**
Do you feel depressed?	**Yes No**
Do you panic when stressed?	**Yes No**
Do you have problems with eating or your appetite?	**Yes No**
Do you cry frequently?	**Yes No**
Have you ever attempted suicide?	**Yes No**
Have you ever seriously thought about hurting yourself?	**Yes No**
Do you have trouble sleeping?	**Yes No**
Have you ever been to a counselor?	**Yes No**

Is there anything else you would like us to know? _____

_____

_____

Other comments or concerns:

_____ _____
Client Signature Date

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 24-hour notice prior to missing an appointment and failure to attend the scheduled appointment. A charge of $50 for each no-show episode will be charged to your credit card.

· 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 5 minutes before 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.

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

· Frequent tardiness 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 Signature: _____

Print Name: _____ Date: _____

Points of Stillness, LLC
2705 Enloe Street
Hudson, WI 54016
715-690-2600
info@pointsofstillness.com

REQUIRED AT FIRST VISIT

Points of Stillness requires clients to keep a credit card on file to pay any balance due after insurance has made payment to us (this includes both primary & secondary insurance companies). This card will be used only to charge any outstanding balance due on the patient's account (co-payments, co-insurance amounts, deductibles, and non-covered services) that have not been paid within 60 days or if payment has not been received after 2 statements have been sent to you from Points of Stillness, LLC.
We will not accept HSA/HRA cards for this form. You are welcome to use your HSA/HRA card to pay your bill by calling or stopping at the front desk, paying by using your private client portal, or paying online from your emailed invoice.

Along with your credit card, we will need a copy of your valid photo ID.

Our office is fully committed to providing appropriate security of our records (including your credit card number), protecting the privacy of our patient's information, and properly maintaining our billing policies in accordance with national HIPAA standards.

Why does Points of Stillness keep my credit card on file? This is becoming the "norm" for medical practices just as it is when you check into a hotel. By being able to charge remaining balances on the credit card for people who don't pay their bills within 60 days or 2 statements, we are able to keep our costs lower, continue to provide you great care, and pay our hard-working staff. Being a small practice, it is important for us to try and always keep your costs low and keeping a credit card on file allows us to do this.

Is my information secure? Absolutely! The information is stored in our HIPAA compliant billing software and only billing staff have access to it.

Will I have the opportunity to pay my bill? Yes! Once your insurance company has paid their portion, you will receive your bill by email, with your balance due. You can also set up a Points of Stillness client portal account where you can access your billing information and pay at any time. (Please stop by the front desk to set up your private client portal account.) You have the option to pay your invoice by check, credit card or cash. Our policy is that we send two statements and wait 60 days. If after that time the bill has not been paid, the credit card will be charged.

What if there is an error, or a charge, I want to dispute? You still have the opportunity to dispute any charge with your credit card company as you would for any other charge. Also, our billing office is available by phone to answer any questions about your bill or any credit card charges.

My insurance always pays everything so why do I need a credit card on file? There are virtually hundreds of different plans, and we cannot know the intricacies of every patient's plan until the claim has been sent. If there is a zero balance, then your credit card information will just remain securely stored and never charged.

I understand all of the above but I either don't carry credit cards or am just not comfortable with this policy? While every rule has an exception, we ask that in this case you fill out an authorization form which would allow us to transfer money from your bank account to ours. This money will be applied to your balance.

What if I have Medicaid? This card will be used for non-covered services, such as supplies, or if your insurance coverage lapses.

This card will only be charged after all these conditions have been met:

- **primary insurance has paid**
- **secondary insurance has paid**
- **2 client statements have been sent to client or guardian and not paid within 60 days**

For questions, please call our billing department Monday – Friday, 8:00 am to 4:00 pm. They will be happy to assist you.

Points of Stillness, LLC
2705 Enloe Street
Hudson, WI 54016
715-690-2600
info@pointsofstillness.com

Credit Card Payment Authorization Form

Client Information:

Client Name:_____

Street:_____

City:_____State: _____Zip:_____

Phone: ( ) _____-_____

Email:_____

Payment Information:

I authorize Points of Stillness, LLC to automatically bill the credit card listed below as specified:

Credit Card Information: Card Type (Circle One): Mastercard Visa Discover American Express

Name:_____

Card Number:_____

Expiration Date: _____/_____ CVV _____ Credit Card Billing Zip Code:_____

_____Notify me via email when my credit card is charged. (Make sure email address above is correct.)

Cardholder Signature: _____Date:_____

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 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.