Thrive Therapies IL, Inc
P: (224)659-3241
F: (773)249-1235

Patient Registration

Patient name: _____ Date:_____
(First) (M.I.) (Last)

Date of Birth: _____/_____/_____ Age:_____ Gender: M F

Address:_____

City/State: _____ Zip Code:_____

Phone: _____ E-mail (optional):_____

If patient is under 18 years old:

Parent/Guardian 1:_____ Relation to Patient:_____

Phone 1:_____ Phone 2: _____

Parent/Guardian 2: _____ Relation to Patient:_____

Phone 1:_____ Phone 2: _____

By signing below, I authorize my therapist to leave messages at the numbers provided above regarding appointments, billing, or other issues relating to patient care. Messages containing sensitive patient health information will not be left.

Patient/Guardian: _____ Date: _____

Policies and Procedures

Payments:
I authorize my therapist to submit health insurance claims for services rendered and any necessary patient health information and/or documentation that may be required for claim submission.

I authorize my therapist to receive payment directly from my insurance company for services rendered. If I receive payment from my insurance company for services, I will return the allotted payment(s) to my therapist within five business days. I understand it is my responsibility to notify my therapist of any changes to my insurance plan in a timely manner.

I authorize my therapist to utilize or disclose patient health information to physicians, other health care professionals, insurance companies, or attorneys involved directly with patient care.

Patient/Guardian: _____ Date: _____

Therapy:
Each therapy session through the Early Intervention program is 60-minutes long, which consists of 45 minutes of direct therapy and 15 minutes of therapy documentation. Private therapy sessions consist of 45 minutes of direct therapy. Sessions may begin 15 minutes prior to or following your scheduled start time as traffic, meetings, or weather conditions may affect when your therapist arrives. Your therapist will contact you if they are more than 15 minutes early or 15 minutes late.

If your child is currently in the Early Intervention program, therapy services will be provided until the child is 3 years old. We also provide at-home private therapy for children of all ages. If you

are interested in continuing speech therapy with your therapist after your child's third birthday, please ask your therapist for more details regarding scheduling and fees.

Cancellations and No-shows:
We are committed to the progress and therapy plan for each patient and we will try our very hardest to create the most accommodating schedule for your family. A regular schedule is best for a patient to make significant gains in therapy. For best results, we strongly encourage patients and patients' families to keep therapy appointments as often as possible. However, we do understand that illnesses and family emergencies happen occasionally. In instances of cancellations, please notify your therapist at least 24-hours in advance. A session is considered a "no-show" when the patient/family does not show for the appointment and did not provide notification. Excessive cancellations and/or **three** no-shows can result in the discontinuation of services. If you are having difficulty keeping appointments or need a change in your appointment time, please talk with your therapist.

Illnesses:
Because we interact daily with other children, some of whom have medical complications and compromised immune systems, and utilize communal materials (which we try our very hardest to keep clean!), colds and illnesses can spread very easily. Therefore, we ask you to be considerate of your therapist and other families and children when your child is not feeling well, as you would want others to do the same in return.
We ask that if your child is exhibiting any of the symptoms below, you cancel your therapy session with your therapist as promptly as possible.

Please **CANCEL** your therapy session if your child:

- **Is vomiting**
- **Has a fever of 100°F or higher**
- **Has a body rash**
- **Has lice**
- **Has diarrhea**
- **Has pink eye**
- **Has a sore throat with swollen glands**

Make-Ups:
Occasionally, your therapist may need to cancel a session due to severe weather conditions, emergencies, illness, IFSP development meetings, etc. Your therapist will provide you with adequate notification of any schedule changes. Make-up sessions can be requested and granted within a two-week period based solely upon the availability of your therapist.

We greatly appreciate your respect and consideration regarding these policies. If you have any questions about these guidelines, please ask your therapist.

By signing below, I verify that I understand the above policies and procedures.

Patient/Guardian: _____ Date: _____

**PLEASE READ THE HIPAA NOTICE OF PRIVACY PRACTICES BEFORE SIGNING BELOW

I verify that I have received, read, and understood the notice of privacy practices.

Patient/Guardian: _____ Date: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the privacy of your protected health information (PHI). PHI includes private information such as:

- Name
- Address
- Birthdates and dates of service (admission, discharge, etc.)
- Phone numbers
- E-mail addresses
- Social security numbers
- Health insurance plan information
- Photos

This information may be utilized in the following instances:

Treatment: Personal information may be used to determine diagnostic and therapy services. This information may also be shared with other professionals involved in your care (i.e., service coordinators, other treating therapists, physicians or other specialists).

Payment: We may use your personal information to bill for services and obtain payment from health plans or other entities if required.

Health Care Operations: We may use your personal information to operate our practice, improve your care, and contact you when necessary. **Patient authorization may not be sought in the case of preventing serious threat to health or safety, abuse or neglect, domestic violence, legal processes (i.e., court or administrative order, subpoena), law enforcement purposes (i.e., compliance of privacy laws), or workers' compensation claims.**

Sharing Your Information

You may request how we share your information. With your consent, we may share your personal information with other individuals involved in your care (i.e., caretaker, babysitter, family members, or others you have identified) or individuals having the right to act on your behalf (i.e., DCFS representatives or foster parents).

We will require your written permission to utilize your personal information for reasons not stated in this notice. If you request your permission to be withdrawn, your personal information will no longer be shared. We will not be able to retract disclosures previously made with your authorization.

Your Rights

Copies of medical records: You may request a copy of your medical records or treatment documents. There may be a reasonable, cost-based fee. All requests will be processed within a 30 day time period.

Correction to medical records: You may ask for a correction to be made to your medical records if you find something to be inaccurate or incomplete. We may decline your request if information is subject to law or reason for request is invalid.

Confidential communications: You may request that we contact you in a specific manner (i.e. phone vs. mail, office phone vs. home phone, etc.) or to send mail to a different address. We will comply with all reasonable requests.

Requesting restrictions: You may request a restriction on the use or sharing of certain health information for treatment, payment, or health care operations. However, we may decline your request if it affects your care.

List of disclosures: You may request a list (accounting) of the times your health information has been shared. Information regarding who we shared it with and why may be obtained as long as the date of request does not exceed six years. There may be a reasonable cost-based fee.

Get a copy of this privacy notice: You may request a copy of this notice at any time.

File a complaint: If you feel that you or your dependents rights have been violated at any time you have the right to file a complaint with us by contacting Stefanie O'Donnell, the assigned privacy officer. You may also contact the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201, calling: 1-877-696-6775, or visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/ . You will not be penalized in any way for filing a complaint. Please adhere by the following when filing a complaint:

- A complaint must be filed in writing, either on paper or electronically.
- A complaint must name the person that is the subject of the complaint and describe the acts or omissions believed to be in violation.
- All complaints must be filed within 180 days of a reported event.

Our Responsibilities:

- We are committed to maintaining the privacy and security of your PHI.
- We will notify you if the privacy of your information is compromised.
- We will follow the privacy practices stated in this notice and provide you a copy of it.
- We have the right to make changes to this notice. If changes occur we will provide you with a new copy.
- We regulate access to your personal information and maintain appropriate security measures to protect it.
- We will dispose of all personal information in an appropriate and secure manner.
- We will retain your personal information for up to seven years following termination of services.

CHILD AND FAMILY CONNECTIONS INFORMED CONSENT & DOCUMENTATION OF RECEIPT OF RIGHTS AND NOTICE OF PRIVACY PRACTICES

Child's Last Name, First Name & Middle Initial _____

Child's Date of Birth (Month/Day/Year) _____

I grant permission for Child and Family Connections (CFC) to collect identifying information and information regarding activities below for my child and family. I understand this information will be stored electronically and in a hard copy case record. The information will be used only for purposes of referral for and review, provision and monitoring of Early Intervention services. My service coordinator, service providers and the Department of Human Services or its designees may see and discuss the information with each other for those purposes. They may also conduct the following activities as necessary to support my child's participation in the Illinois Early Intervention program:

a) Provide developmental screenings, evaluations and assessments.
b) Collect and review reports of developmental screenings, evaluations and assessments and services.
c) Determine eligibility for Early Intervention initially and annually.
d) Determine family participation fees.
e) Collect insurance information and share with my providers.
f) Assist my family in development of appropriate Individualized Family Service Plans.
g) Provide early intervention services as authorized through the Illinois Early Intervention Services System.

My child and family's Early Intervention rights were explained to me and I understand them. I acknowledge that I have received a copy of the document entitled, "State of Illinois Infant/Toddler and Family Rights Under IDEA for the Early Intervention System", which describes these rights, the procedures the Early Intervention system follows and the steps I can take to assure that my Early Intervention rights are guaranteed.

I understand I have a right to disagree with your decisions and to file a state complaint or request mediation or an impartial administrative hearing. I understand I have a right to inspect, copy, review, and amend Early Intervention records you maintain on my family and me. I understand I have a right to privacy regarding the information collected about my child and family in the Early Intervention program. I understand you agree to maintain the information confidentially.

I acknowledge that I have received the "Notice of Privacy Practices" describing how information about my child and my family may be used and disclosed.

I understand that applying to the Early Intervention Services System indicates that I am giving permission for my child's private or public insurance be utilized to the extent that it covers some or all of my family's Early Intervention services subject to fees.

I understand I do not have to agree to each of the Early Intervention services offered or to any of the services. However, failure to accept such services may prohibit the developmental opportunities for my child. I understand I may withdraw this permission in writing at any time except to the extent it has already been acted upon. I understand my refusal to grant permission or withdrawal of permission will result in a discontinuation of participation in the Early Intervention program.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

***Notice to Receiving Agency/Person*:** Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.