Patient Name: _____
Insurance ID: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____ Sex: M / F

Parent/Guardian Name: _____ Phone: (_____)_____

Address: _____ City: _____ St: _____ Zip: _____

Social Security Number: _____/_____/_____ Dominant Language: ☐English ☐Spanish ☐_____

Patient/Parent/Guardian Information:

Employer: _____ Phone: (___) _____

Address: _____ City: _____ St: _____ Zip: _____

Emergency Contact:_____ Relationship:_____

Address: _____

City: _____ St: _____ Zip:_____ Phone: (____)_____

Referring Physician: _____ Primary Physician: _____

Referring MD's Phone: (___)_____ **Primary MD's Phone:** (___)_____

Referring Doctors Office: _____ Primary MD's Office: _____

Primary Insurance: _____ Address: _____

Phone: (___)_____ City: _____ St: _____ Zip:_____

Name of Insured: _____ Relation to Patient: ☐ Parent ☐ Self ☐ Spouse

Policy Number: _____ Group #: _____ ☐ Other: _____

Employer: _____ Ph: _____ City: _____ St: _____ Zip: _____

Patient Release and Insurance Authorization: (Initials are required for release of Medical Information and Authorization of Payment)

Initials _____ I hereby authorize payment directly to the Center for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to me, but not to exceed the physician's and/or the Institutes regular charges for therapy for this treatment period.

Initials _____ I further authorize the release of any medical information required by my insurance carrier(s) and/or treating physicians.

Notice: Misrepresentation and/or falsification of essential information requested in this document may be subject to monetary fines and/or imprisonment, if convicted, under federal law.

My signature Indicates that I have read and understood the packet provided upon my admission to the Center. This packet includes a consent form, insurance and medical release form, and insurance benefits assignment / financial agreement.

_____ _____
Signature of Patient/Parent or Legal Guardian Date

_____ _____
Facility Representative Date

ADMISSION FORM
COMPREHENSIVE TREATMENT PLAN AGREEMENT

The following is a description of this clinic's policies regarding the comprehensive treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies, please ask a representative of this clinic before signing.

Non-Discrimination Policy

The Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information, contact the Front Office Supervisor or TTY State Relay at 1 800 735-2988.

Speech, Hearing and Visual assistance communication guides are available at no charge and upon request. For further information, contact the Front Office Supervisor or TTY State Relay at 1 800 735-2988.

Initials_____

Scheduling Policy and Consent to Treat

I, the Patient/Parent or Legal Guardian hereby consent to treatment for therapy services. I further understand that once a weekly treatment appointment schedule has been determined, this clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advanced notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapists as well.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that I have up to two weeks from the time of cancellation to make up for the cancelled session. I understand that I will lose the cancelled session if not made-up within two weeks. I understand that a make-up session may occur with this clinics substitute therapist, our regular therapist, or another skilled therapist with this clinic and may be offered as a separate session or by adding on additional time to several sessions.

I understand that notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment(s). I understand that we are entitled to make up sessions for vacation time two weeks before or following our vacation time.

I understand that the clinic is open except in cases of severe weather conditions requiring businesses to close. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and if the opening of the clinic has been delayed. Families may cancel treatment if they do not wish to travel in poor weather conditions. I understand that if treatment time falls on a federal holiday that I am encouraged to make up these sessions.

I understand that if our therapist is ill or on vacation, the clinic will provide a substitute therapist to ensure continuation of services. This clinic will make every effort to schedule the therapist at our regularly scheduled appointment time. If this cannot occur, the clinic will provide an alternate appointment time.

I understand that if we do not keep a scheduled appointment or if we do not cancel a session before the session is scheduled to begin, that time of treatment is forfeited.

I have read and agree to abide by the above policies.

Initials_____

Patient Name: _____ Insurance ID: _____

Office Policy for Families with Child Clients

I understand that infants and toddlers often need to be accompanied by a parent during treatment; all other individuals are asked to please wait in the waiting room during treatment sessions. Observations of my child's treatment session may be scheduled upon request.

I understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and monitoring my child's play in the waiting room. I understand that the clinic prefers I wait during the session so that I am able to monitor some of my child's treatment when appropriate. I understand that it is the policy of this clinic that a parent or legal guardian must remain in the clinic during treatment sessions.

Initials_____

Acknowledgement of Risk

I understand that there is some risk inherent in the use of therapeutic equipment at this clinic, and I agree to indemnify and hold the clinic harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment.

Initials_____

Coordination of Care

I give permission to have this clinic contact and discuss my child's/my case with all persons whose names I have provided as professionals working with my child or myself.

Initials_____

I give permission for this clinic to send copies of progress reports to all referral sources whose names I have provided.

Initials_____

Teaching and Education of Students

I give permission for occupational, physical, and speech therapy students to observe me or my child's therapy. I understand that I will be notified before such observation takes place.

Initials_____

Consent to Photograph

I give permission for photographs/videotapes to be taken of myself, or my child for educational and/or promotional purposes. I understand that any photographs or videotapes will be reviewed by me before they are released.

Initials_____

_____ _____

Signature of Patient/Parent or Legal Guardian Date

_____ _____

Signature of Witness Date

Patient Name: _____ Insurance ID: _____

ADVANCE DIRECTIVES POLICY

Early Bird Pediatric Therapy Clinic, Inc. requires each person receiving treatment in this facility to sign the following notice to be in compliance with the Self-Determination Act regarding advance directives. In this facility should a patient suffer a life-threatening situation this signed notice implies agreement on the resuscitation and transfer of the individual to a higher medical care. If in the event the person has an Advance Directive and has provided it to our office, we will honor the patient's directive. Any further concerns regarding this policy should be addressed with your physician.

I have read the above policy and understand the information in this policy.

_____
Name of Patient [Please print name]

_____ _____
Signature of Patient/Parent or Legal Guardian Date

_____ _____
Signature of Facility Witness Date

STATEMENT OF PATIENT BILL OF RIGHTS

In recognition of the responsibility of this facility in the rendering of patient care, these rights are affirmed in the policies and procedures of

Early Bird Pediatric Therapy Clinic, Inc.

Service(s) without regard to race, color, age, sex, sexual orientation, religion, marital status, handicap, national origin or sponsor:
The patient's cultural, psychological, spiritual & personal values are respected.
Reasonable physical access to the Facility
Privacy appropriate to care
Considerate, respectful and dignified care
A secure environment for self and property
The opportunity to communicate effectively

Uncompromised care regardless of the presentation of complaints relating to the quality of previous care received in this Facility.

Strict confidential treatment of disclosures and records and to opportunity to approve or refuse the release of such information, except when required by law

The opportunity to obtain complete and current information from the patient's therapist concerning the diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on the patient's behalf.
To know, by name the doctor responsible for coordinating the patient's care.

The opportunity to participate in decisions involving the patient's health care, unless contraindicated by concerns for the patient's health.

Information necessary from the patient's doctor to give an informed consent prior to the start of any procedure and/or treatment including:

- Significant medical risks involved
- Probable duration of incapacitation
- Information and alternatives for medical care or treatment
- Consequences of not complying with therapy
- Name of person responsible for procedures and/or treatment

Opportunity to refuse treatment to the extent permitted by law and information regarding the medical consequences of refusal or noncompliance with prescribed therapy

Patients have the right to expect a quick response to reports of pain.
Your reports of pain will be believed;

- Information about pain and pain relief measures;
- A concerned staff committed to pain prevention and management;
- Health professionals who respond quickly to reports of pain; and
- Effective pain management

By signature herein, I certify I have received a copy of the Patient Bill of Rights and was given the opportunity to ask questions regarding this notice with company Administrator or their designee.

_____ _____
Patient or Guardian Signature Date

_____ _____
Company representative Signature Date

Early Bird Pediatric Therapy Clinic, Inc.

SUBJECT: Patient Responsibilities

PURPOSE

Inform the patients of their responsibilities as a participant in the total care process.

POLICY

All patients are responsible for:

1. Behavior that shows respect and consideration for other patients, family, visitors and personnel of the Center.

2. Assuring that the financial obligations for health care rendered are paid in a timely manner.

3. Accepting consequences of their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given to them by the doctor or their health care team member.

4. Providing the Center to the best of their knowledge with an accurate and complete medical history about present complaints, past illnesses, hospitalization, surgeries, and existence of advance directives, medications and other pertinent data.

5. Follow the plan of treatment recommended by the doctor primarily responsible for the patient's care and/or other personnel authorized by the Center to instruct patients.

6. Notifying the Center of any change in their condition or circumstances.

7. Keeping their appointment for scheduled services. If they anticipate a delay or must cancel the scheduled service, it is their responsibility to notify the Center as soon as possible.

8. The disposition of their valuables while at the Center is the responsibility of the patient or guardian.

Patient or Parent (if minor): _____ Date: ___ / ___ / ___

Witness by: _____ Date: ___ / ___ / ___

Patient Name _____

Date _____

EARLY BIRD PEDIATRIC THERAPY CLINIC, INC.

COVID-19 PATIENT PROTOCOL

SYMPTOMATIC CASES

- Patients showing symptoms related to COVID-19, or with family members experiencing symptoms known to occur with COVID-19, will **NOT** be seen until they have received negative results.

EXPOSURE CASES

- Patient may return to the clinic after he/she, as well as anyone else in their household exposed to COVID-19, has negative test results.

POSITIVE CASES

- Patient may return to in-clinic treatments after everyone in their household has negative test results for COVID-19.
- COVID-19 positive patients, and their entire households, should remain in quarantine for at least 10 days and until:
  - **NO** fever is present for 24 hours; as well as
  - Showing symptom improvements as indicated per the CDC.
- **It is our policy that patients are to return to therapy until negative COVID-19 results have been received by everyone in their household.** Due to the nature of our industry, Early Bird Pediatric Therapy employees are taking every precaution necessary to ensure the safety and wellbeing of medically fragile individuals – including all of our patients and staff, as well as their families.

ATTENDANCE POLICY EXCEPTIONS

- Appointments missed due to any COVID-19 reasons will **NOT** be counted against the patient's attendance rate percentages.
- Patients missing appointments due to COVID-19 related reasons are to be allowed to place their treatments on a temporary hold and will **NOT** be penalized until they are clear to return.
- Patients have the option to request treatments via telehealth as an alternative to receiving in-clinic treatments while they stay home during the COVID-19 pandemic, contingent in the coverage provided by their medical insurance.

I have read and agree to abide by the above policies.

_____ _____

Parent/Guardian Signature Witness Signature

Patient Name:

ID:

Attendance Policy

Regular attendance and participation in the therapy your child receives is very important for their progress and development. Without this participation, therapy will not be effective.

It is the policy of Early Bird Pediatric Therapy Clinic that patients abide by the following:

- Regular attendance is required of all patients. Regular attendance is defined as 75% of attendance at the time the visit is scheduled of each authorization period. Excessive tardiness will count negatively towards attendance.
- If the patient is unable to attend, the clinic must be notified 24 hours in advance.
- Make-up appointments will be made available to avoid disruptions in therapy services. If there is prior knowledge of missed appointments (ex. Doctor appointments, vacation, etc.), parents may schedule make-up appointments in advance.

Early Bird Pediatric Therapy has the discretion to reduce therapy treatment and/or discharge patients that fall below 75% attendance and notify the child's PCP.

Attendance Supplemental Information

Hospitalizations – Any hospitalization that resulted in 48-hour admission or longer requires written approval from the patient's PCP prior to continuing therapy sessions.

Appointment Holds – Early Bird Pediatric Therapy allows for patients to hold their scheduled slots for 30 days for the following reasons:

- Medical problems/complications that prevents the patient from receiving therapy
- Loss of insurance coverage
- Loss of insurance authorization (including denial/reduction of therapy sessions pending appeals)

After the 30 days, Early Bird Pediatric Therapy staff has the discretion to remove the visit(s) from the schedule and will attempt to reschedule upon their return to the same/similar time slot.

Treatment Availability

Please select days and times your child will be available once therapy is ready to be scheduled *(select at least three days)*.

☐ **M** ☐ **T** ☐ **W** ☐ **TH** ☐ **F**

☐ Morning (8:00 AM – 11:00 AM)

☐ Afternoon (12:00 PM – 3:00 PM)

☐ Evening (4:00 PM – 7:00 PM)

Patient/Parent Signature: _____ Date: _____

NOTICE OF HIPAA PRIVACY PRACTICE CONSENT

I HEREBY CONFIRM THAT THE HIPAA POLICY HAS BEEN PROVIDED TO THE CLIENT/PARENT/GUARDIAN AT TIME OF THIS ADMISSION

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with **Early Bird Pediatric Therapy Clinic, Inc.** or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with **Early Bird Pediatric Therapy Clinic, Inc.** contact the Privacy Officer at **915-271-8030.** Your complaint must be filed within 180 days of when you knew or should have known that the act occurred.

The address for the Office of Civil Rights is:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

- -

ACKNOWLEDGEMENT

Patient Name: ______________________________________

Date of Birth: ______________________________________

I acknowledge that **Early Bird Pediatric Therapy Clinic, Inc.** provided me with a written copy of its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

____ ____________________________

Patient Signature Date

____ ____________________________

Personal Representative Signature (if applicable) Relationship to Patient

SPEECH THERAPY COMPLIANT NOTICE ACKNOWLEDGEMENT

As required by the Texas Administrative Code for Speech-Language Pathology and Audiology, article §741.45 regarding Consumer Information and Display of License, we hereby provide you with the following information on how to file a consumer complaint:

A person who provides speech-language pathology and/or audiology services to clients must be licensed, unless exempted by State law.

A consumer who wishes to file a complaint against an individual licensed by the applicable State Board may:

1. Visit at: https://www.tdlr.texas.gov/complaints/
2. Fax to: (512) 539-5698
3. Write and mail to:

   TDLR (ENFORCEMENT DIVISION)
   P.O. BOX 12157
   AUSTIN, TX 78711-2157

4. Write and deliver or courier to:

   TDLR
   920 COLORADO ST
   AUSTIN, TX 78701-2332

Speech Therapy Consumer Complaint information given to patient/guardian.

_____
Name of patient [Please print name]

_____ _____
Signature of patient/parent/legal guardian Date

_____ _____
Signature of facility witness Date

211 EMERGENCY DISASTER PROGRAM ASSISTANCE

Please indicate who will be registering the client with 2-1-1 Emergency Disaster Services provided through the Texas Department of State Health Services.

- ☐ Patient/Parent/Guardian
- ☐ Family Member/Power of Attorney
- ☐ Facility Representative
- ☐ I decline to register the patient for 211 services
- ☐ Other: _____

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Facility Representative Date

PATIENT CONTINUITY OF CARE AND RISK CLASSIFICATION FORM

PATIENT NAME:_____AGE:_____DATE OF BIRTH: _____

ALLERGIES:

- ☐ NO KNOWN DRUG ALLERGIES (NKDA)
- ☐ DRUG ALLERGIES:_____
- ☐ OTHER ALLERGIES: _____

DATE:	MEDICATION:	DOSAGE/FREQUENCY/ROUTE (ORAL, INJECTION, TOPICAL)	SIGNATURE:

PATIENT'S BLOOD TYPE: [CIRCLE PATIENT'S BLOOD TYPE]

A + A- B+ B- AB+ AB- O+ O- NOT KNOWN

ADVANCE DIRECTIVE PREFERENCE: [CHECK ONE ANSWER]

_____THE PATIENT DOES NOT HAVE AN ADVANCE DIRECTIVE PREFERENCE

_____THE PATIENT DOES HAVE AN ADVANCE DIRECTIVE PREFERENCE (PROVIDE COPY TO CLINIC)

EMERGENCY CONTACTS:

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

To be completed by clinical personnel: During disaster situations, therapy may be postponed for up to 8 hrs.- **level 1**; postponed for 9-48 hrs. **level 2**; postponed for 49-71 hrs. **level 3**; postponed for 72-96+ hrs. **level 4.**

EMERGENCY CLASSIFICATION: [circle level] 1 2 3 4

EARLY BIRD
PEDIATRIC THERAPY

Medical History

Demographic/Family History

Child's Name (First, Middle, Last):_____

Date of Birth:_____

How old is your child today?_____

Gender: Male/Female (circle one)

Mother's Name:_____

Father's Name:_____

Brothers/Sisters Names and Ages (if only child, please write ONLY CHILD in box)

Name	Age

Who lives in the home (include all siblings, family members, friends, step-parents, step-siblings if applicable):_____

_____

What language(s) is/are primarily spoken in the home?_____

What are your current concerns? _____

_____

EARLY BIRD
PEDIATRIC THERAPY

Medical History

What was the length of pregnancy in weeks?_____

Any problems during pregnancy (medical, social, environmental): □Yes □No

If yes, please list:_____

Did child's mother use any medication used while pregnant: □Yes □No

If yes, please list:_____

Did child's mother use any illicit drugs/alcohol while pregnant: □Yes □NoIf yes, please list:_____

How was baby delivered? (check one)

□Vaginal □Emergency Cesarean Section □Scheduled Cesarean Section

What was the child's weight/height when baby was born? Weight_____Height_____

Were there any medical problems with the child at the time of birth? □Yes □No

If yes, please list:_____

Was the child admitted to the Neonatal Intensive Care Unit (NICU) after delivery? □Yes □No

If yes, please include reason for admission into NICU and how many days/weeks/months before discharge:_____

Were there any difficulties with feeding? __Yes __No

If yes, please list:_____

Developmental History

Does your child do any of the following?

Drool	__No	__Yes
Drink from a bottle	__No	__Yes
Babble Actively	__No	__Yes
Suck thumb	__No	__Yes
Use 2-3 words together	__No	__Yes
Object to certain foods	__No	__Yes

Does your child currently drink/eat the following?

Breast Milk	__No	__Yes
Formula	__No	__Yes
Baby Food	__No	__Yes
Mashed table foods	__No	__Yes
Table Foods	__No	__Yes

Modified diet: _____

Does your child understand the following?

A few words	__No	__Yes
Simple directions	__No	__Yes
Almost everything said	__No	__Yes
Sentences	__No	__Yes

Check how your child lets you know what they want:

__Cries	__Makes a few sounds
__Uses gestures	__Uses many words/phrases
__Uses a few words	__Says many words at one time
__Says 2-3 words	__Uses long sentences

EARLY BIRD
PEDIATRIC THERAPY

Please write age that child was able to do the following independently without parent'sassistance (include months if possible), and write an **X** if child has ***NOT*** met milestone.

	Sit		Walk while holding onto objects
	Roll		Walk without holding onto anything
	Crawl		Kick Ball
	Stand while holding onto object		Throw ball
	Stand without holding anything		Catch ball
	Remove Socks		Finger Feed
	Remove Shoes		Eats with utensils
	Remove Shirt		Babble
	Remove Pants		Turn Towards Sound Source
	Put on Socks		Coo
	Put on Shirt		Babble
	Put on shoes		Use simple words
	Tie Shoes		Use 3 word sentences
	Draw basic strokes (I, +, X,O)		Put hands together (Clap)
	Draws simple shapes (□ ◊▲♥)		Points to objects or people
	Write single letters		Waives Hi and Bye
	Write Words		Toilet Trained

EARLY BIRD
PEDIATRIC THERAPY

Has your child ever gained skills and lost them? □Yes □No

If yes, please list:_____

Please list all of child's diagnoses given by his PCP/Specialist (This includes physical, mental,and chronic diagnoses)

Diagnosis	**Month/Year of Diagnosis**	**PCP/Specialist whoDiagnosed**

When was last visit to his PCP?_____

Current Height: _____ Current Weight: _____

Does your child have any on-going medical conditions? (required surgeries, implanted medical devices, etc...) □Yes □No

If yes, please list:_____

_____

Is your child allergic to any food or medication? □Yes □No

If yes, please list:_____

Does your child have any dietary restrictions? (lactose intolerant, ketogenic diet, gluten intolerant, etc…)□Yes □No

If yes, please list:_____

Has your child ever had any surgeries? □Yes □No

If yes, please include surgery month/year:_____

_____

Does your child have history of seizures? □Yes □No

If yes, when was his/her last seizure:_____

Does your child use durable medical equipment (wheelchair, medical bed, crutches, etc…)? □Yes □No

If yes, please list:_____

Aside from PCP, does child receive services from a specialist? □Yes □No

If yes, please list:

Name of Specialist	Specialist Type (ex. Neurologist,allergy doctor, etc.)	Month/Year of Last Visit

Has your child ever received occupational, physical, or speech therapy before? □Yes □No

If yes, which therapy and month/year of last appointment:_____

_____

Has your child ever received Early Childhood Intervention (ECI) services? □Yes □No

If yes, what month/year did your child start ECI services?_____

What month/year did your child stop ECI services?_____

Do any family members have a history of a learning disability or speech/language problems? __Yes __No

If yes, please list: _____

Educational

Does your child attend school? □Yes □No

If yes, continue with the section. If no, please skip this section.

What school does your child attend?_____

What grade is your child in? _____

Has your child ever repeated a grade? □Yes □No

If yes, which grade(s):_____

What is child's primary language at school?_____

Is your child receiving therapies at school? □Yes □No

If yes, please list therapies he/she is receiving and how often:_____

_____

Is child enrolled in any special education services? □Yes □No

If yes, please list month/year of last ARD:_____

Please check of the following as it pertains to your child

	Does not do homework		Poor handwriting		Poor reading skills
	Noncompliant in class		Does not remain seated		Excessive time to complete assignments
	Test Anxiety		Easily distracted in class		Poor spelling
	Talks inappropriately inclass		Makes careless errors		Poor math
	Forgets to complete assignments		Messy and disorganized		Aggressive with othersat school

Hearing

Has your child's hearing ever been tested? □Yes □No

If yes, when was last test completed (month/year):_____

What were the results?_____

Has your child ever had an ear infection? □Yes □No

If yes, please list month/year of last ear infection:_____

Has a doctor ever said that child as fluid in his/her ears? □Yes□NoHas

your child ever had tubes places in his/her ears? □Yes □No

If yes, please when? _____

Have you ever had any concerns about your child's ability to hear normally? □Yes □No

If yes, please list concerns:_____

Vision

When was your child's last vision exam (month/year)?_____

Does your child wear glasses? □Yes □No

Does your child have any other eye conditions (near-sighted, far-sighted, chronic eye conditions, etc)? □Yes □No

If yes, please list:_____

Social History

With whom does your child live? _____

Does your child reside in another home more than 50% of the time? __Yes __No

If yes, with whom? _____

Please check off all that apply to your child:

Social Interaction

	No friends		Few Friends		Poor Sleep
	Makes friendseasily		Extremely shyaround others		Poor Appetite
	Difficulty being redirected (being toldwhat to do)		Impulsive		Aggressive
	Stubborn		Frequent temper outbursts		Throws objects
	Destroys Toys		Not interested inpeople		Hard to separate fromprimary caregiver (ex. Mother or father)
	Wants to be leftalone		Self-harming behaviors		Hits other people/animals

EARLY BIRD
PEDIATRIC THERAPY

What concerns do you have regarding your child's development (Ex. Social Interactions, Communication, Play, Language, Self-Help Skills, and Behavior)?

What goals would you like your child to meet in therapy?

Does your child go by any nicknames?

What activities and/or toys does your child enjoy?

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month_____ Day_____ Year_____

ADDRESS _____

_____

CITY_____ **STATE**_____ **ZIP**_____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Early Bird Pediatric Therapy Clinic, Inc.
Address 2114 N Zaragoza Suite C1
City El Paso State Texas Zip Code 79938
Phone 915-271-8030 FAX 915-257-3051

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ FAX _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ **Treatment/continuing medical care**
- ☐ **Personal use**
- ☐ **Billing or claims**
- ☐ **Insurance**
- ☐ **Legal purposes**
- ☐ **Disability determination**
- ☐ **School**
- ☐ **Employment**
- ☐ **Other** _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health**	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month_____ Day_____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **Date**

Printed name of legally authorized representative (if applicable): _____
If representative, specify relationship to the individual: ¨ Parent of minor ¨ Guardian ¨ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **Date**

ACKNOWLEDGMENT OF RECEIPT OF POLICIES

1. Notice of Privacy Practices
2. Statement of Patient Bill of Rights
3. Sick Policy Consent
4. Patient Responsibilities
5. Advance Directive Policy
6. Advance Directive and Do Not Resuscitate Orders
7. State of Texas Emergency Assistance Registry (STEAR)

I acknowledge that **Early Bird Pediatric Therapy Clinic, Inc.** provided me with a written copy of the above policies and was afforded the opportunity to read and ask questions.

Signature of Patient/Parent or Legal Guardian	Signature of Facility Witness
Date	Date