Pediatric Therapy Services
1057 East Henrietta Road, Suite 500 Rochester, NY 14623 Phones: 585.427.2977 • 585.427.7610 Fax: 585.427.7410

August 28, 2018

Parent/Guardian:			
Client Name:		**DOB:**	
Appointment Date:			
Therapist:			

Dear Parent/Guardian:

Welcome to Step by Step Pediatric Therapy Services. In order to begin your child's therapy, we ask that you complete the enclosed forms, which includes:

- Welcome Letter
- Patient Information/background
- Permission for evaluation/privacy notice
- Email consent
- Payment agreement
- Directions and location

Please review, sign and bring this paperwork with you to the appointment. **Please take care to ensure that you have filled out both sides of each form.** Please bring a copy of your insurance card to the appointment. We look forward to seeing you.

Please let us know if you have any questions. Thank you!

Sincerely,

Heather Hanson PT, DPT, PCS

Heather Hanson
Clinic Supervisor

Stacia Paganelli MA, CCC-SLP

Stacia Paganelli
Clinic Supervisor

STEP by STEP
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Welcome to Step by Step Therapy Services!

We are looking forward to your upcoming initial evaluation. Please plan to arrive 10-15 minutes prior to your appointment time to help expedite our new patient registration process. Your initial evaluation appointment will last approximately 1 hour. During that time, the individual therapist that you will be working with will use a combination of questions, observations, and direct interactions with your child to complete a detailed assessment of your concerns and overall development. Following your appointment, you will receive any information that is necessary to schedule additional appointments and establish your child's individual plan of care. In addition, a full report will be sent to your referring physician in approximately 5-10 days. Please bring the following with you based on which evaluation your child will be attending:

Feeding Evaluations:

Promptly alert us to any allergies that you or your child is suspected or confirmed to have. Please bring the following items with you based on your child's age:

Infants under 6 months of age: pacifier, bottle, formula/breastmilk

Infants transitioning to solids: bib, spoon, one accepted puree, one puree that is challenging, bottle and/or cup, formula/breastmilk

Toddlers: bib, 3 preferred foods, 3 non-preferred foods (difficult due to taste, texture or presentation), preferred cup, list of currently accepted foods

Preschool and School-Age children: 2 preferred foods, 1 non-preferred food, list of consistently accepted foods

Speech and Language Evaluations:

Please bring any recent evaluations or reports if appropriate. If your child uses augmentative communication, please bring your device or materials.

Occupational and Physical Therapy Evaluations:

Please bring any equipment that you are using with your child including splints, braces, walkers, etc. Please wear comfortable clothing and shoes appropriate for movement.

If you have any questions regarding materials needed for your child's specific evaluation, please do not hesitate to contact our office at 427-7610.

Thank you,

Step by Step Clinical Evaluators

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Patient Information

Please indicate who may be bringing your child to subsequent therapy sessions and what information can be communicated with them in the form below:

Child's Name: DOB:

Parent's Name:	Parent's Name:
Address:	Address:
Phone:	Phone:
Work Phone:	Work Phone:
Email Address:	Email Address:

In the space below, please list and number anyone other than parent or guardian with permission to:
#1: Schedule and attend appointments

#2: Receive and provide disclosure of medical information

#3: Make a medical decision in the event of a emergency

#	Name	Relationship	Phone Number(s)
#	Name	Relationship	Phone Number(s)
#	Name	Relationship	Phone Number(s)

Please list your child's emergency contact:

Name	Relationship	Phone Number(s)

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Patient Information (continued)

PERSONAL

Patient name: Date of birth:

BACKGROUND

What brings you to Step by Step Pediatric Therapy Services?

_____

_____

Who referred your child for therapy?_____

Has your child received this type of therapy before?_____
If yes, by whom?_____
When?_____
Why?_____

_____

Does your child currently receive medical care?_____
If yes, why?_____

_____

List all illnesses and approximate dates:_____

_____

_____

List all surgeries and dates:_____

_____

_____

_____

Does your child have allergies?_____
If yes, describe:_____

_____

Does your child take any medications? _____
If yes, list ALL medications and dosages: _____

_____

_____ _____

Signature of parent/guardian Date

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Please review the Notice of Privacy Practices and complete this form.

Child's Name _____ Date of Birth _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and audits.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

PERMISSION FOR EVALUATION AND THERAPY TREATMENT

I give Step by Step Pediatric Therapy Services permission to evaluate and provide therapy to the above name child:

_____

Print Name of Parent/Surrogate or Legal Guardian

_____ _____

Signature Date

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Consent for the Use of Unencrypted Electronic Data Sharing

At your request, you have chosen to communicate personally identifiable information concerning your treatment by e-mail or text message *without the use of encryption*.

This includes sending appointment reminders via e-mail or test message. Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Sending personally identifiable information by e-mail or text message has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail and text messages can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent.
- E-mail and text messages senders can misaddress an e-mail, and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail or text messages may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Note: E-mail/ Texting contact is for your benefit only. Information is not shared without additional consent from you. However, the exchange is not inherently secure.

Please print clearly and legibly

Patient Name:_____ DOB:_____

E-mail: _____

Cell Phone: _____

Signature: _____

Date: _____

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Payment Agreement

_____ _____

Name of Child Date of Birth

_____ _____

Name of Parent / Guardian

I understand I am responsible for payment to Step by Step (SBS) for office visits. Co-payments are due at the time of service. Other patient liabilities will be billed after submitting to insurance.* _____
Initial

I agree to give SBS at least 24 hours notice when canceling an appointment, with exceptions made at the discretion of the Therapist**. If I do not give sufficient notice when canceling or I miss an appointment, I understand that I will be responsible for a $50 visit fee.**

_____
Initial

_____ _____

Parent / Guardian Signature Date

**For your convenience, we accept Visa and MasterCard. Please note that some flexible spending account debit cards cannot be processed; contact your card's administrator to ensure SBS is an approved provider.*

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Appointment Reminder Consent

Date: _____

Name of child: _____

Complete this form and sign below to give your permission for Step by Step to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

☐ Step by Step may send email messages to confirm my upcoming appointments to email: _____

_____

☐ Step by Step may send cell phone text messages to confirm my upcoming appointments to Cell phone number: _____.
I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

_____

Signature of Patient or Guardian

_____

Date

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Selective Release Form

Patient's Name:_____ DOB: _____

I give my consent to Step by Step Pediatric Therapy Services to exchange information with:

_____

Type of information to be shared:

_____

_____

I understand that this release is valid as long as_____ is serviced by Step by Step Pediatric Therapy Services.

This consent shall not be used for the release of confidential, HIV-related information without additional specific consent.

_____
Print Name of Patient (if over 18) or Parent/ Surrogate or Legal Guardian

_____
Signature

_____
Witness Signature.

_____
Date

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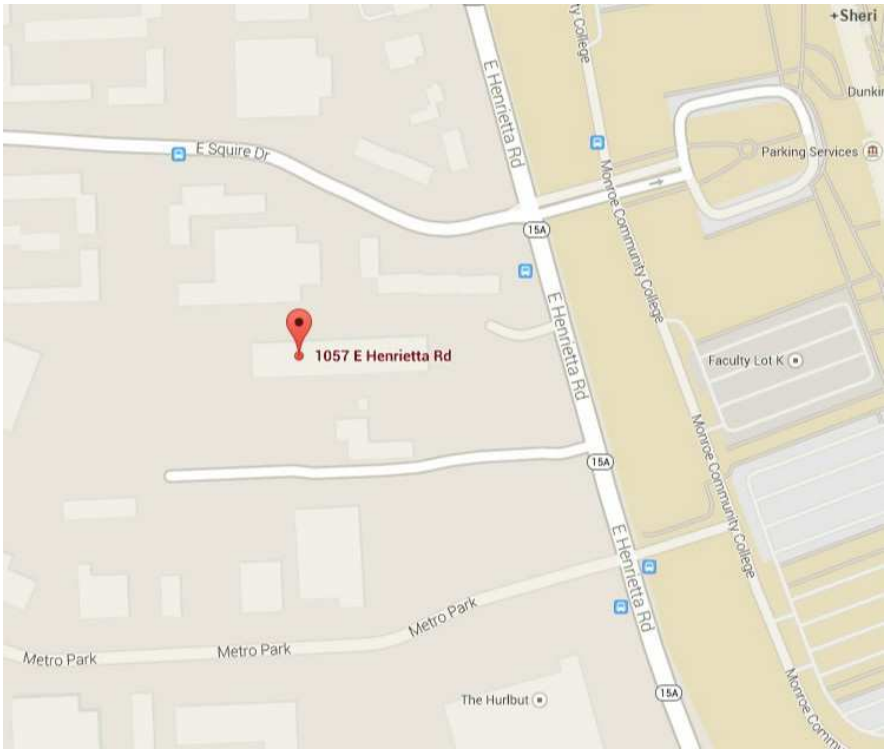
Located on the west side of East Henrietta Road, just north of Brighton-Henrietta Townline Road. Easy access to I-390 at East Henrietta Road.



From the East:

I-490 W to I-590S to I-390 N. Exit 16 for NY-15A/E Henrietta Rd/NY-15-W Henrietta Road. Left at E Henrietta Rd/RT 15A. We are on the right, just past the Animal Hospital, across from MCC.

From the West:

I-490E towards Rochester. Exit 9B to merge onto I-390 S toward airport Exit 16B for East Henrietta Road Turn right onto East Henrietta Road. We are on the right, just past the Animal Hospital, across from MCC.

From the South:

I-390N Exit 16 for NY-15A/E Henrietta Rd/NY-15-W Henrietta Road. Left at E Henrietta Rd/RT 15A. We are on the right, just past the Animal Hospital, across from MCC.

From the North:

I-590S. Exit onto I-390N. Exit 16 for NY-15A/E Henrietta Rd/NY-15-W Henrietta Road. Left at E Henrietta Rd/RT 15A. We are on the right, just past the Animal Hospital, across from MCC.