1505 N Alma School Rd
Suite 2
Chandler, AZ 85224
Office: 480.626.4142
Fax: 480.626.7370

Dear Parent/Caregiver,

Welcome to Stepping Stones Pediatric Therapy! We feel fortunate to have the opportunity to work with you and your child to further his or her development.

The enclosed packet is **important information which is needed before we can proceed with your child's therapies**. Please complete, sign, and date the three stapled forms and return in the envelope provided. Please date the forms prior to your child's first treatment. As soon as these forms are completed, we will be able to begin therapy services for your child. Please take a few minutes and fill these out as best as possible. If you have any questions, please feel free to contact our office.

In addition, please be aware of the following important SSPT policies and procedures. We recommend that you keep this information for future reference.

MEDICAL RELEASE ACKNOWLEDGEMENT

Any change in the medical status of your child including surgeries, hospitalizations or extended periods of illness require a new prescription from your child's doctor stating therapies may resume. Therefore, please inform your therapist as soon as you become aware if your child will undergo any type of medical procedure. If your child is hospitalized or seen for any type of emergency, we ask that you advise your child's therapist as soon possible. **I understand that therapy services cannot resume until a new prescription is received from my child's doctor, in compliance with DDD requirements and medical standards of practice.**

CANCELLATION POLICY

If you need to cancel an appointment, we request a 24-hour notice. If you cancel within less than 24 hours of your scheduled appointment, you may be charged for ½ of the scheduled session*. Please note that frequent cancellations may result in discontinuation of services.
***Patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges**.

NO SHOW POLICY

If you do not call to cancel and fail to keep your appointment, you will be charged for ½ of the scheduled session*. **I understand that insurance will not pay for such "no shows" or late cancellation charges — and that I am responsible for all such charges. If you have 1 or more no shows, we reserve the right to discontinue services.**
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Again, we look forward to providing the best possible services for your child and family. You will be contacted soon by the therapist, so you can schedule or confirm your child's evaluation or first ongoing visit. Let us know how we can assist you further!

Sincerely,

Stepping Stones Pediatric Therapy

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you as a patient of Stepping Stones Pediatric Therapy may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review this notice carefully.

Our commitment to your privacy

Stepping Stones Pediatric Therapy is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We are also required by law to provide you with this notice of our legal duties and the privacy we maintain in our practice concerning your health information. We realize these laws are complicated, but we must provide the following important information to you. We also reserve the right to amend or revise this Notice of Privacy Practices as necessary.

Your rights regarding your health information

The health and billing records we maintain are the physical property of Stepping Stones Pediatric Therapy. However, the information in these records belongs to you. You have the right to:

1. Request a restriction on certain disclosures and uses of your health information in writing to our office. We are not required to grant the request, but we will comply with any request granted;
2. Request that you be allowed to inspect and copy your health record and billing record – you may exercise this request by delivering the request in writing to the office;
3. Appeal a denial of access to your protected health information except in certain circumstances;
4. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
5. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
6. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
7. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and
8. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you would like to exercise any of the above rights, please contact Lindsay Cavner, OTR, owner of Stepping Stones Pediatric Therapy in person or in writing. We will assist you in the steps you should take to exercise your rights.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities that are authorized by law to collect information
2. To health oversight agencies for activities authorized by law. These may include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions: civil administrative and criminal procedures or actions, or other monitoring programs of the government.
3. Lawsuits and similar proceedings in response to a court or administrative order;
4. If required to do so by a law enforcement official;
5. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat;
6. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities;

7. To federal officials for intelligence and national security activities authorized by law;
8. To correctional institutions or law enforcement officials if you are an inmate or under the custody off a law enforcement official; and
9. For Workers' Compensation and similar programs.

Other disclosures and uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Right to a copy of this notice

You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give a copy of this Notice to you at any time.

Right to file a complaint

If you believe your privacy rights have been violated, you may file a complaint with Stepping Stones Pediatric Therapy or with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this Notice of Privacy Practices, please contact:

Stepping Stones Pediatric Therapy
Attn: Lindsay Cavner, OTR, Owner
1505 N Alma School Rd, Suite 2
Chandler, AZ 85224
480-626-4142

I hereby acknowledge that I have been presented with a copy of Stepping Stones Pediatric Therapy's Notice of Privacy Practices.

_____
Printed Name of **Patient**

_____
Signature of **Parent/Guardian**

_____
Date

Please return this signed form to: Stepping Stones Pediatric Therapy
1505 N Alma School Rd, Suite 2
Chandler, AZ 85224

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Stepping Stones Pediatric Therapy, LLC

Client Data and History

Name: _____ Date of Birth_____
Address:_____
Telephone:_____ Alt. Contact_____
Primary Care Physician: _____
Address:_____
Telephone:_____ Fax:_____
Additional Physicians (include first and last names, specialties):_____
_____
Reason For Referral:_____
_____
Diagnosis/Concerns: _____
_____

Developmental History

Difficulties during pregnancy:_____
Difficulties during labor /delivery:_____
Child was delivered at_____ in_____
(Hospital) (city, state)
Birth Weight:_____ Apgar Scores (if known):_____ Premature: Yes No # of weeks:_____
Length of stay in hospital: _____ Difficulties with breathing after birth? Yes No _____
Any difficulties during the first two weeks of life?_____
Difficulty with swallowing, sucking, drinking, or chewing?_____
Normal weight gain? Yes No comments:_____

Please list all allergies: Food: _____
Medications:_____

Previous Surgeries (include dates)_____
_____
List Medications currently taking (please spell clearly):_____
_____
Has your child had seizures? Yes No Type of seizures:_____
Has hearing been assessed? Yes No Results:_____
Has vision been assessed? Yes No Results:_____
History of ear infections? Yes No Frequency? _____ Tubes placed ?_____

When did your child first:

Roll over (back to tummy):_____
Sit independently:_____
Crawl:_____
Walk Unaided:_____
Say First Words:_____
Talk in phrases or sentences:_____

Did your baby babble by 6 months of age? Yes No Explain:_____
Did your child eat and drink independently by age 2? Yes No_____
Does your child dress and undress independently? Yes No_____
Is your child toilet trained? Yes No _____
My child sleeps from _____ p.m. to _____ a.m. Naps from _____p.m. to _____a.m.
Does your child have tantrums? Yes No Explain:_____
What Behavioral /Discipline techniques work for your child?_____
List all care providers for your child? (i.e. daycare, grandparents) _____

INSURANCE INFORMATION

Patient Name	Birth date	DDD Assist # (If applicable)	Sex	SS#
Address	City		State	Zip code

Home Phone	Cell Phone	Email	Diagnoses
Father/Guardian	Cell Phone	Mother/Guardian	Work Phone
Primary Physician	Phone Number	DDD Support Coordinator	
AHCCCS Plan	***AHCCCS ID Number***		***ALTCS (Title 19)*** Y N

Primary Health Insurance Plan (Other than AHCCCS Plan)	Employer		
Policy Holder	Relationship to Patient	SS#	Birth date
Policy Holder Address (*if different from patient*)	City	State	Zip code
ID or Policy Number	Group Number		
Claims Address:			Phone

Secondary Health Insurance Plan (Other than AHCCCS Plan)	Employer		
Policy Holder		SS#	Birth date
ID or Policy Number	Group Number		
Claims Address:			Phone

MEDICAL INFORMATION RELEASE

I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies, other health care agencies or school districts. I also authorize the release of medical records or copies of such and request that they be transferred to Stepping Stones Pediatric Therapy, 1505 N Alma School Rd, Suite 2 Chandler, AZ 85224.

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FINANCIAL POLICY

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand*. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance.

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ASSIGNMENT OF BENEFITS

I request payment of authorized insurance benefits be made on my behalf to Stepping Stones Pediatric Therapy. By signing, I also agree to the above terms.

Signature of Parent/Guardian _____ Date _____