



Consent to Treat and Use of Protected Health (PHI)

1. Consent to Treat

I, the undersigned, authorize Early Learning Partners, Inc ("ELP") and its licensed therapists, early interventionists, and assistants to provide evaluation, assessment, and treatment services to my child.

I understand that these services may include therapies such as occupational, speech-language pathology, or other early intervention services provided in the home or community.

2. Use and Disclosure of health information

I understand that ELP will collect, use, disclose my child's health information, including Protected Health Information (PHI), as necessary to:

- Provide treatment and coordinate care with other healthcare providers and agencies involved in my child's care.
- Bill for services with insurance companies, regional centers, or other payers.
- Manage and operate the business (such as quality assurance, staff training, and record keeping).

3. Privacy Practices

I have received or been offered a copy of Early Learning Partners Notice of Privacy Practices, which explain how my child's health information is protected and how I can exercise my privacy rights.

4. Communication Preferences

I authorize ELP to contact me by:

Phone call, text message and/or email.

5. Consent for Use of Electronic Signatures

I agree that electronic signatures and records related to my child's care and treatment are acceptable and have the same legal effect as handwritten signatures.

6. Revocation of Consent:

I understand that I may withdraw this consent at any time by providing written notice to Early Learning Partners, Inc. However, withdrawal will not affect any actions taken prior to the withdrawal.

7. Parent/Guardian Acknowledgment and Signature

I have read and understand this consent form. I voluntarily agree to the treatment of my child and the use/disclosure of health information as described above.

First Name:

Signature (Parent/Guardian):

Last Name: _____

Date:



ELP Attendance & Cancellation Policy

At Early Learning Partners, Inc. (ELP) we are committed to providing your child with high-quality, consistent therapy and early intervention. Regular attendance is a key part of your child's development progress -- reserved therapy times are limited. To ensure the best outcomes for all children we serve, please review the following attendance guidelines.

Client Cancellations

- We request at least 24 hour notice for cancellations whenever possible.
- Valid reasons may include: Family emergencies and child/family illness

Please notify your therapist/interventionist directly as soon as you know you need to cancel.

While providers are not required to offer make-up sessions, they will do their best to accommodate your child's needs.

Illness Policy

We know children sometimes get sick. If your child is unwell:

- Notify your provider as soon as possible if illness will prevent your session
- If your child has a mild cold with no fever and is otherwise playful and active, services may still be provided.
- Masking options are available upon request for added safety

No-Show & Confirmation Policy

Confirmation

- We will send you a text reminder the day before your scheduled session.
- You must respond affirmatively by the end of that day to confirm your appointment.
- If we don't receive your confirmation, we may mark your session as a no-show or release your time slot to another client.

No-Show Definition

A No-Show is any appointment missed without prior notice (via call, text, or email)

- After two (2) no-shows, your services may be suspended at the supervisor's discretion

We understand emergencies happen. Services suspensions are handled on a case-by-case basis with empathy and care.

Provider Absence or Cancellation

If your provider needs to cancel for any reason.

They will notify you as soon as possible.

Make-up sessions will be offered whenever possible, or a qualified substitute may be provided. However, make-up is not guaranteed.

TCRC Policy Reminder

- Missed sessions can only be made up within the same calendar month they occurred.
- ELP staff are not reimbursed for missed sessions.
- This is why timely, clear communication is essential -- your cancellation may allow another child to benefit from a make-up session.



Your rights as a Parent or Caregiver

- You have the right to pause or reduce the frequency of services at any time
- You may request a different provider if you feel your current therapist/interventionist is not a good fit for your child.
- You may contact a supervisor at any time with questions or concerns.

Contact Information

If you need to cancel, reschedule, or speak with a supervisor:

Rachel Price, MA, OTR/L

Co-Director

(805)-223-1392

Ellen Nightingale, MA, CCC-SLP

Co-Director

(908)-917-6777

At ELP, we are here to support your family every step of the way. Thank you for helping us provide the most consistent and effective care for your child.

Acknowledgment of Receipt:

We'll ask you to sign a form saying you received this notice. It doesn't mean you agree with everything -- just that you have received the information.

First Name:

Signature (Parent/Guardian):

Last Name: _____

Date:



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective Date: 3/11/2025

1. Introduction

Early Learning Partners, Inc. ("we," "our," or "us") is committed to protecting your privacy. This Notice of Privacy Practices explains how we handle your health information under federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act (CMIA). It also includes updates based on effective changes in 2025.

2. How We Use and Disclose Your Protected Health Information

Under the HIPAA Privacy Rule, we may use and share your protected health information (PHI) without additional written permission for the following purposes: Treatment - Sharing information with doctors, therapists, and other healthcare professionals involved in your care.

Examples of treatment would include assessments, consultations, meetings, therapy sessions, etc.

Help Manage the Health Care Treatment Received - Appointment reminders (phone, mail, email) or providing information on treatment options or other health related service including release of information to approved friends and family members that are directly involved in your care or who assist in taking care of you.

Payment - Processing insurance claims and billing for services provided.? An example of this would be billing your health plan for your therapy services.

Healthcare Operations - Improving quality of care, training, and internal management.? An example would include a periodic assessment of our documentation protocols, etc.

Public Health and Safety - Reporting communicable diseases, abuse, or neglect as required by law.

Legal and Compliance Obligations - Responding to court orders, law enforcement requests, and regulatory requirements.

Emergency Situations - Providing necessary information to prevent serious threats to health or safety.

For any other purposes we will not use or share your PHI without your explicit written authorization. You have the right to revoke any authorization you provide at any time.

3. Our Duties to Protect Your Health Information Privacy

We are required by law to:

- Maintain the privacy and security of your protected health information.
- Provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices.
- Notify you in the event of a breach of your unsecured PHI.
- Follow the terms of this notice unless revised, in which case we will provide an updated version.

4. Your Privacy Rights

You have the right to:

- Access, inspect, and obtain a copy of your health records.
- Request corrections to your records if they are incorrect or incomplete.
- Request restrictions on certain uses and disclosures of your PHI.



- Receive confidential communications in the manner you specify (e.g., mail, email, phone, in person).
- Request a list (accounting) of disclosures of your health information.
- Revoke your authorization for the use of your PHI(except when required by law).
- File a complaint if you believe your privacy rights have been violated.

For any other purposes we will not use or share your PHI without your explicit written authorization. You have the right to revoke any authorization you provide at any time.

5. How to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with:

- Early Learning Partners, Inc. Compliance Officer at info@earlylearningpartnersinc.com?
- The U.S. Department of Health & Human Services (HHS) Office for Civil Rights via their website at <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>, or phone at (877)-696-6775.

We will not retaliate against you for filing a complaint.

6. Additional California Privacy Rights

Under California law, you have additional protections, including: CMIA Protections - Your medical information cannot be disclosed to third parties for non-healthcare-related purposes without your written consent.

7. How We Protect Your Information

We take reasonable measures to protect your health information from unauthorized access, use, or disclosure. This includes physical, technical, and administrative safeguards. However, no security system is completely foolproof.

8. Changes to This Notice

We may update this Notice of Privacy Practices as required by law. The latest version will always be available on our website and upon request.

9. Contact Information

If you have any questions about this notice please contact: Early Learning Partners, Inc. Compliance Officer at info@earlylearningpartnersinc.com.

10. Acknowledgment of Receipt

The law requires us to ask you to confirm in writing that you received this Notice of Privacy Practices. However:

- You are not required to sign the acknowledgement form.
- Signing does not mean you agree to any special uses or disclosures of your health information.
- Refusing to sign the acknowledgement does not prevent us from using or sharing your health information as permitted by HIPAA.

If you choose not to sign, we will make a record of your refusal.

First Name: _____ Last Name: _____

Signature (Parent/Guardian): _____

Date: _____



ELP Media Release for Training Purposes

How it may be used

I understand the media will only be used for educational materials/staff training. My child will only be identified by first name.

What we are asking:

I give permission for Early Learning Partners, Inc. (ELP) and their partners or contractors to document interaction by photographs, video, and audio.

My Rights

- I do not have to sign this form. It will not affect my child's services.
- I can revoke this authorization at any time in writing.
- Media may be stored and used until I revoke my consent in writing.

Authorization

I understand what this form allows and give ELP permission to use the listed media of myself and/or my child as described above.

First Name:

Last Name: _____

Signature (Parent/Guardian): _____

Date: _____

Contact info (optional for questions or follow-up):

hr@earlylearningpartnersinc.com

661-406-0358