Consent for Services

☐ I authorize Early Learning Partners, Inc. to render appropriate evaluation and therapy services to the client/child named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Early Learning Partners, Inc. in writing. In addition, Early Learning Partners, Inc., may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent Early Learning Partners, Inc. rendering evaluation and therapy services to the client/my child named below.

______________________________ ______________________

Print Name of Child Date

____

Child's Date of Birth

______________________________ ______________________

Signature of Parent or Legal Guardian Relationship to Child

NOTICE OF PRIVACY PRACTICES

This notice describes:
-How medical information about you may be used and disclosed
-How you can get access to your medical records
Please review this information carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.
Treatment means providing, coordinating or managing health care and related services by one or more health care providers. Examples of treatment would include assessments, consultations, meetings, therapy sessions, etc.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your health plan for your therapy services.
Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected health information when we are required to do so in a confidential manner as we are required to do so by federal, state or local law. Any other disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our privacy officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.

- The right to request an amendment to your protected health information
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We may use or disclose your protected health information without your authorization only as required by law.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information or to file a complaint please contact:
U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
877-696-6775

I, ______________________________ have received a copy of Early Learning Partners Notice of Privacy with an effective date of April 1, 2018.

Signature of Parent or Legal Guardian:_________________________________

Date:________________

Signature of Witness:____

Date:________________

Consent to Photograph/Video

Child's name:_______________________________

Date of birth:_______________________________

I, ___________________________, hereby authorize and give consent to allow Early Learning Partners to photograph/video my child for educational, supervision, and training purposes. I understand that the videos may be shown to therapists and educators for training purposes.

I __________________________ additionally consent to allow photographs of my child for promotional/marketing materials (i.e., website, flyers, social media, etc.)

Signature of Parent or Legal Guardian:_______________________________

Relationship to child:___________________________________

Date:____

Authorization to Exchange, Obtain or Release Information

Child's Name: ______________________________________ Date of Birth: ________________________

I ___________________________ (parent) hereby grant Early Learning Partners therapy staff including:

____ (list any therapists and interventionists who treat your child) permission to communicate with the following person or agency:

Name:

Contact Information:

Information to Be Released:
☐ Medical History
☐ Therapy Evaluation
☐ SLP ☐ OT ☐ PT ☐ Other: _______________
☐ Treatment Notes
☐ SLP ☐ OT ☐ PT ☐ Other: _______________
☐ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)
☐ Coordinating care with other professionals
☐ Providing continuity of services
☐ Updating therapeutic progress
☐ Other ____

☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.
☐ I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

______________________________ ______________________
Print Name of Client Date

______________________________ ______________________
Signature of Client or Legal Representative Relationship to Client

Communication Preference Form

Client Name: ___________________________ **Date of Birth: ___________________________**

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to Ellen Nightingale to do the following:

Written Documentation and Verbal Information

☐ I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.

☐ I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication via USPS in an unmarked envelope.

☐ I elect to receive clinical information in person or via telephone through the number provided.

☐ I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information

Individual's Name	Relationship to Client	Email Address and/or Phone Number
1.		
2.		

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

______________________________ ______________________

Print Name of Client Date

______________________________ ______________________

Signature of Client or Legal Representative Relationship to Client

Attendance and Cancellation Policy

In order to offer you the highest quality of therapy, regular attendance is crucial. We cannot reserve therapy time for clients who do not maintain consistent attendance.

Cancellation:
A Cancellation is any appointment cancelled at least 24 hours in advance or before 8 am on the day of the appointment. For planned absences (i.e., family vacations, previously scheduled doctor's appointments, etc.), we request that you notify your provider once you know you need to change your appointment time. Providers are not required to make up therapy time due to a change in your schedule; but will do their best to accommodate families when at least a 2-week time frame is given.

Illness:
If you or your child has a fever, diarrhea, vomiting within a 24-hour period, please call as soon as possible to cancel your session. If your child has a runny nose or a slight cold, this is fine. Please just make your provider aware and therapy activities can be modified accordingly.

No Shows:
A No Show is any missed appointment without a phone call or text message to cancel as defined above. If you fail to cancel an appointment, your therapist cannot use that time for another client. After 2 no-show appointments, you will be taken off a regular therapy schedule and placed on a waiting list for therapy.

Provider's Absence/Vacations:
Providers may occasionally be absent due to illness, meetings, vacations, or unforeseen natural disasters. Providers have full caseloads and treat several families on different days. Make-ups are at the provider's discretion, not at the provider's obligation. A substitute therapist may offer families additional services when provider absences occur. Providers are asked to give families the same courtesy and appropriate notice for cancellations and scheduled vacations, so families can make alternate plans.

________I have read and agree to comply with this Attendance & Cancellation Policy

_________________________ _____________________

Parent Signature Date