Notice of Points of Stillness, LLC Privacy Practices

Points of Stillness, LLC is required to provide patients with this Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed as well as how you can obtain access to this information. Please review carefully.

Medical Information may be use for the following purposes by POINTS OF STILLNESS, LLC:

- Treatment: We will use the information to provide, coordinate and manage care and treatment. For example, we will release reports to another provider who is involved in you care.
- Payment: We will use information to receive payment for services we provide. For example, we will disclose information in order to submit bills or claims to insurance companies and /or Medicare or State funded plans.
- Health Care Operations: We will use information for certain activities related to business functions of Points of Stillness, LLC. For example, we may use or disclose information for quality assurance activities.
- Appointment Reminders and Other Health Information: Information may be used to provide you with information about new or alternative treatments or other health care services that may be of interest to you.
- Family Members or Other Responsible People: You may agree to have verbal information about your treatment shared with a family member or designee.
- Other Uses or Disclosures: Disclosures or use information in the following cases: when required by law; for public health activities; relating to victims of abuse/neglect/domestic violence; for health oversight activities; for judicial and administrative proceedings to the extent permitted by law; for law enforcement purposes, as permitted or required by law; to coroners/medical examiners/funeral directors, as permitted by law; for organ donation purposes; for research purposes under certain circumstances: to avert a serious threat to health or safety: for certain specialized government functions, such as military discharge and national security and intelligence; and for workers' compensation purposes.

Your individual Privacy Right as a patient includes the following:

- Restrict Use and Disclosure: You have the right to request that Points of Stillness, LLC not use your treatment information in certain ways or for certain purposes. You may also request that we not provide treatment information to certain individuals. However, Points of Stillness, LLC has the right to refuse you request, particularly when law requires it. In the case where emergency treatment is necessary, we will ask the person(s) who receive the information not to further use or disclose the information.
- Provide Confidentiality: You have the right to request that Points of Stillness, LLC provide you with your treatment information in a confidential manner. For example, you can request that we send bills and other mailings to a different address or that we notify you of this kind of information in another way, such as by telephone call. You must make this request in writing and specify another address or means of communication. Under certain circumstances, we may deny your request. We will agree to your request to the extent we are able to assure accuracy in doing so. Your request for such confidentiality may require that you provide us with information on how you will pay your bills.
- Research: Under certain circumstances we may use and disclose treatment information about you for research purposes. We will only do this with you written authorization, or with the approval of the special board that will ensure that there is only a minimal risk to your privacy.
- Inspection and Copy: You have the right to ask to see and copy your treatment records, unless there is information protected by law. In our practice your treatment record is limited to reports and billing information. We may charge you fees associated with copying costs.
- Change Information or Amend Medical Records: You have the right to request in writing that we change information in your treatment record if we were the originator of such information. If you request is denied, you can write a statement of disagreement with the denial that we will keep with your treatment information.
- Accounting of Disclosure: You have the right to request an accounting of disclosures. This would include releasing treatment information about you, which was not related to treatment, payment, healthcare operations, or information you requested to release to another facility or persons. Requests for accountings will not include those made prior to May 1, 2010.
- Paper Copy of Points of Stillness, LLC Patient Notice of Privacy Practices: If you have received this notice of the treatment information privacy rights electronically, you may ask us to provide you with a paper copy.
- Privacy Violations: If you feel your treatment information privacy rights have been violated, you may file a complaint with the Secretary of Health and Humans Services and/or with Points of Stillness, LLC. Filing a complaint will not affect the quality of the services you receive from Points of Stillness; LLC and you will not be retaliated against for filing a complaint.

The U.S. Secretary of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free: 1-877-696-6775

The effective date of this notice is May 1, 2010. Points of Stillness, LLC reserves the right to change this notice and will make the new information available to you in person or by posting it in our office.

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

PEDIATRIC SPEECH INTAKE

CLIENT INFORMATION: (Please Print)

Client Last Name: _____**First Name:** _____**Middle Initial:** _____

Street/PO Box: _____ City: _____State:_____ Zip: _____

Client Date of Birth: _____/_____/_____ **Client Birth Gender:** (circle) Male / Female

Parent/Guardian Name: _____ Single/Married/Divorced (circle one)

Street/PO Box: _____ City: _____State:_____ Zip: _____

Cell Phone: ( ) _____ **Email:** (please print) _____

If divorced, please provide a copy of any custody agreement.

Parent/Guardian Name: _____ Single/Married/Divorced (circle one)

Street/PO Box: _____ City: _____State:_____ Zip: _____

Cell Phone: ( ) _____ Email: (please print) _____

If divorced, please provide a copy of any custody agreement.

Primary Medical Insurance Company_____**Group#**_____**ID#**_____

Policy Holder Name _____Relationship to Client___Self__Parent__Other

Policy Holder Date of Birth _____/_____/_____

Secondary Medical Insurance Company_____**Group#**_____**ID#**_____

Policy Holder Name _____Relationship to Client___Self__Parent__Other

Policy Holder Date of Birth _____/_____/_____

Employer Name: _____ **Employer Phone:** _____

Physician Name: _____ **Physician Phone:** _____

Physician's Clinic Name and Address: _____

Provide Insurance Card to Front Desk.

Would you like to sign up for the Points of Stillness newsletter? YES or NO

I have read, understand, and agree to the Notice of Points of Stillness, LLC Privacy Practices.

_____ _____

Client Name Date

_____ _____

Parent/Guardian/Legal Representative Signature Relationship to Client

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

CLIENT AUTHORIZATION: **(Please Print)**

CLIENT LAST NAME: _____ FIRST: _____
CLIENT DATE OF BIRTH: _____/_____/_____

I authorize Points of Stillness, LLC to release to physicians currently involved in my care and to my insurance carriers, all health information, including reports related to my current reason for seeking service. I also authorize my referring or consulting physician and or other examination facility to release medical records to Points of Stillness, LLC.

I authorize payment of my insurance claims related to services I receive at Points of Stillness, LLC to be made directly to Points of Stillness, LLC. I understand this authorization is valid one year from date of signing.

I agree to be financially responsible for any charges not covered by my worker's compensation insurance, auto insurance, personal injury carrier, Medicare, or my private health insurance carrier. If I have no insurance, I understand I am financially responsible for all charges incurred. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Points of Stillness, LLC for any services I receive at Points of Stillness, LLC. I authorize any holder of hospital or medical information about me to release to CMS (Medicare) and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

PHOTO AND VIDEO RELEASE

_____ I authorize employees of Points of Stillness, LLC to photograph my child for purpose of internal intake records.

_____ I authorize employees of Points of Stillness, LLC to photograph/videotape my child for the purpose of: in center clinical discussion and teaching, publications such as brochures and flyers, use on clinic website and Facebook page, presentations in workshops to other professionals or parents, and for RDI evaluation and treatment of Autism.

_____ I do NOT authorize photos/videotaping of my child.

This consent is valid for the full term of my child's therapy at Points of Stillness, LLC unless otherwise allowed by law. I understand I may revoke (cancel) this consent, in writing, at any time. Revoking consent does not apply to information that has already been disclosed.
My signature below means that I have read, understand, and give my consent.

RELEASE OF INFORMATION

I authorize the release and receipt of information about this client's therapeutic treatment for the purpose of:
_____ Collaborating care with other caregivers or agencies providing services
_____ Legal proceedings
_____ Transfer of care
_____ Research (no name included)

Please list authorized contacts (such as doctors, agencies, caregivers) below:

1) Functional Kids _____
2) _____
3) _____
4) _____
5) _____
6) _____

_____ _____
Client Name Date

_____ _____
Parent/Guardian/Legal Representative Signature Relationship to Client

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

CLIENT INTAKE: (Please Print)

CLIENT LAST NAME: _____ FIRST: _____

I authorize the following therapy (check all that apply)
We will consult with you before including any of the therapy programs below.

_____ Speech & Language Therapy
_____ Occupational Therapy
_____ Acuscope
_____ Myopulse
_____ Craniosacral Therapy
_____ Auditory Integration/Therapeutic Listening Protocols
_____ Integrated Care
_____ Sensory Processing Intervention
_____ AcuEnergetics®
_____ Cold Laser

_____ _____
Client Name Date

_____ _____
Parent/Guardian/Legal Representative Signature Relationship to Client

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

PEDIATRIC SPEECH AND LANGUAGE EVALUATION QUESTIONNARE: **(Please Print)**

CLIENT LAST NAME: _____ FIRST: _____

The following questions are posed to help in compiling a more complete picture of your child from conception and early infancy to present developmental stages. Please answer the following questions as best you can. If there is not adequate space for your comments, please continue to write on the back of this form.

What are your current concerns/reason for a speech and language evaluation?

_____

_____

_____

When was the concern first noticed? _____

_____

Has the concern/problem changed since it was first noticed? Yes No
If so, how? _____

_____

Is your child aware of the problem? Yes No
If yes, how does he or she feel about it? _____

_____

Has your child had Speech Therapy in the past? Yes No
If so, where and when? _____

Was your child discharged or was care discontinued and why? _____

_____

Do other family members have any speech, motor, cognitive, or other disorders/delays? Yes No
If yes, please describe:

_____

_____

_____

Is your child currently or has previously been under the care of any other health professionals?

_____ Psychologist When? _____Where? _____
_____ Vision Therapist When? _____Where? _____
_____ Physical Therapist When? _____Where? _____
_____ Occupational Therapist When? _____Where? _____
_____ Chiropractor When? _____Where? _____
_____ Other _____ When? _____Where? _____

Does your child have siblings? If so, what are their ages? _____

_____

Does your child attend school and/or day care? Where? When? _____

_____

PREGNANCY AND BIRTH

Were there any infections/illnesses during pregnancy? Yes No
If yes, specify : _____

Were there any medications or drugs taken during pregnancy? Yes No
If yes, specify : _____

Was there any unusual stress during pregnancy? Yes No
If yes, specify : _____

Was the pregnancy full term? Yes No

Premature delivery? Yes No
If yes, how early? _____

Was labor normal? Yes No
If no, specify: (cesarean section, breech, sideways, cord around neck, forceps used, etc)
_____

Was medication given during delivery? Yes No
If yes, specify : _____

Were there any complications? seizures jaundice congenital defects other:_____

Was there a need for: oxygen transfusions tube feedings other: _____

Did your child cry immediately after birth? Yes No
If no, please explain: _____

How long was the length of your child's hospital stay? _____

Was your child breast fed or bottle fed? _____

Please state any other difficulties or special care: _____

MEDICAL INFORMATION

Diagnosis: _____

Accidents or Injuries (type and date)_____
_____
_____

Recent Illnesses _____
_____

Current Medications/Dosage/Frequency? _____
_____

Known medication allergies: _____

Known food allergies: _____

History of major illnesses:
If applicable, provide the approximate age at which the child suffered the following illnesses and conditions:

High fever: _____ Pneumonia: _____

Meningitis: _____ Seizures: _____

Headaches: _____Tonsillitis: _____

Other: _____

History of hospitalizations:
_____
_____
_____
_____

History of ear infections? Yes No If yes, how many and approximate age? _____

Does your child have or have they ever had PE tubes? Yes No When were they placed? _____

When was your child's last hearing exam? _____ Results: _____

Is your child currently on medication for an ear infection? Yes No If yes, how long? _____

Does your child have a history of acid reflux? Yes No If yes, for how long? _____

Are there any diagnosed mental, physical, or emotional disabilities? _____

Are there any concerns about physical, sexual, mental, or emotional abuse? _____

Diet restrictions? Yes No If yes, please describe: _____

Are immunizations up to date? Yes No

My child currently sleeps/naps: inconsistently well restless other: _____

SOCIAL/EDUCATION HISTORY

Name of School/Daycare: _____ Grade: _____

Teacher's Name: _____ Phone: _____

Times/Days in school/daycare :_____

How is your child doing academically/pre-academically? _____
_____

Does your child receive special services in school? Yes No If yes, describe: _____
_____

Does your child currently have an IEP? Yes No **If yes, provide a copy.**

Activities your child enjoys: _____
_____

Does your child prefer to do these activities alone or with other siblings/peers? _____

Does your child make friends easily? Yes No If no, explain: _____
_____

What do you see as your child's strengths? _____
_____

DEVELOPMENTAL MILESTONES

Please list the age that your child did the following and answer questions below (in months):

Roll _____ Sit _____ Crawl on hands/knees _____ Walk _____ Babble _____

Say a first word _____ Finger feed _____ Use a spoon _____ Drink from a cup _____

Is your child potty trained? Yes No

Does your child use single words? Yes No If yes, please provide. (example: no, mom, dad, dog, etc.)

_____

Does your child combine words Yes No If yes, please provide. (example: me go, daddy shoe, etc.)

_____

Does your child use simple questions? Yes No If yes, please provide. (example: Where's doggie?, etc.)

_____

Does your child engage in conversation? Yes No If yes, provide examples.

_____

What percentage of time do you understand your child's speech? 100% 75% 50% 25% 0%

What percentage of the time do **others** understand your child's speech? 100% 75% 50% 25% 0%

Did your child meet his/her developmental milestones in relation to peers or siblings? Yes No

Do you have concerns or questions about his/her development? Yes No

Is your child able to follow simple 1-2 step directions? Yes No Sometimes

Is your child able to answer yes/no questions? Yes No Sometimes

Is your child able to answer wh-questions? Yes No If yes, which? _____

Does your child appear to make appropriate eye-contact? Yes No Sometimes

Describe your child's demeanor/behavior as an infant: _____

_____

_____

_____

_____

_____

FEEDING/ORAL MOTOR DEVELOPMENT

Does your child demonstrate difficulties with any of the follow? Please circle all that apply.

Choking/Gagging
Food or liquid coming out of nose/mouth
Sucking (under 18 months)
Eats too much
Eats too little
Swallowing
Messy eater
Behavior
Chewing
Biting through solids/soft foods
Refuses oral feeding
Drooling
Picky eater
Unable to feed self (over 18 months)
Vomiting
Pocketing food in cheek

Please describe in detail any difficulties circled above: _____

_____

_____

_____

_____

_____

How does your child take most liquids? Bottle, Sippy-Cup, Straw, Open-Mouth Cup, Other _____

How much does your child usually drink per day? _____

Does your child feed him/herself? Yes No If yes, what does he/she use? Fingers ___ Spoon ___ Fork ___

What does your child eat in a typical day? *Please list the foods, drinks, and approximate amounts:*
Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

Does your child snack throughout the day? Yes No

Your child's appetite is best described as: *(circle best answer)*

a. Poor
b. Fair
c. Good
d. Excellent
e. Eats too much

Who usually feeds your child? *(circle best answer)*

a. Mother
b. Father
c. Caregiver
d. Him/Herself

Is there a difference in eating patterns depending on who feeds your child? Yes No
If yes, please describe: _____

Do your child's food preferences and habits match that of the family? Yes No
If no, please explain: _____

Consistency/Type of Food	Does Eat	Will Eat, but not preferred item	Cannot or refuses to eat	Never tried
Pureed foods (applesauce, pudding, etc.)				
Mixed textured foods (cereal with milk, chunky mashed potatoes, etc.)				
Chewy foods (fruit snacks, taffy, etc.)				
Crunchy foods (crackers, chips, etc.)				
Cold foods (ice cream, yogurt, etc.)				
Hot foods (soup, oatmeal, etc.)				
Meats (chicken, hamburger, etc.)				
Dairy (milk, cheese, etc.)				
Vegetables (carrots, corn, peas, etc.)				
Fruits (apple, banana, orange, etc.)				
Grains (bread, pasta, cereal, etc.)				

Does your child demonstrate any of the following during mealtime? *(circle any that apply)*

a. Throws food
b. Spits food
c. Cries, screams
d. Leave the table before finishing
e. Messy eater
f. Takes food off others' plate
g. Refuses to eat
h. Walks around while eating
i. Other: _____

How long does it take for your child to eat a meal?

a. Less than 10 minutes
b. 10-20 minutes
c. 20-30 minutes
d. 30-60 minutes
e. Over 60 minutes

Are mealtimes a pleasant experience? Yes No

Does your child mind being touched around or in the mouth? Yes No

Does your child drool? Yes No

If yes, indicate how often. ___Rarely ___Occasionally ___Frequently ___Constantly

Does your child sleep with a bottle or cup? Yes No

Does your child use a pacifier? Yes No

Does your child suck his/her thumb or fingers? Yes No

Are your child's teeth slow to come in? Yes No

Does your child have any cavities? Yes No

Are your child's teeth misaligned? Yes No

Who is responsible for brushing the child's teeth at home? Child or Parent/Caregiver

Have you noticed any bleeding or foul odor in your child's mouth? Yes No

Does your child have problems with constipation, diarrhea, or bowel movements? Yes No
If so, please explain: _____

Does your child resist having his/her teeth brushed? Yes No

Does your child resist having his/her hair brushed? Yes No

Does your child resist having his/her face washed? Yes No

PLEASE USE SPACE BELOW FOR FURTHER COMMENTS OR INFORMATION ABOUT YOUR CHILD:

_____

_____

_____

_____

THANK YOU! THIS INFORMATION HELPS US TO BEST PROVIDE SERVICE TO YOUR CHILD.

Points of Stillness Attendance and Cancellation Policy

Points of Stillness strives to provide exceptional care and the highest quality of services possible for all clients. In order to do so, regular attendance is necessary to establish a positive treatment routine and to build and maintain skills. Inconsistent attendance hinders achievement of goals and prevents clients from receiving the full benefit from therapy. In order to encourage consistent attendance, Points of Stillness has established the following policy:

CANCELLATIONS: We understand that due to illness or other unexpected events it may be necessary for you to cancel a therapy appointment.

· Notice is expected prior to the appointment, and at least 24 hours' notice is requested.

· It is your responsibility to notify/call the front desk as soon as possible if you need to cancel a therapy appointment and provide a reason for the cancellation.

· Please notify the clinic at least two weeks prior to vacations or other planned obligations that will result in missing a scheduled treatment session. Please review our travel policy for additional information.

· Excessive cancellations (more than three appointments within two months) may result in the loss of the client's treatment spot, discussion about finding an alternate appointment time and/or placement on a waiting list. Extenuating circumstances will be taken into consideration.

NO-SHOWS: A no-show is defined as failure to give notice prior to missing an appointment and failure to attend the scheduled appointment.

· Two no shows may result in the loss of the client's treatment spot. Extenuating circumstances will be considered.

PUNCTUALITY: We ask that clients consistently arrive on time for all scheduled appointments in order to receive the optimal benefits from therapy.

· Please arrive no more than five minutes early for each session and notify the clinic if you are going to be arriving late.

· If your child is attending therapy, you are required to be here at least five minutes prior to the end of the scheduled session.

· Punctuality for appointments allows adequate therapist/patient interaction. This also gives us time to report outcomes to parents and disinfect therapy spaces.

· Frequent tardiness for drop off and/or pick up (more than 10 minutes late) may result in loss of the client's treatment spot.

High levels of cancellations or missed appointments may adversely affect therapy progress and success at therapy. We value your time and the time our therapists devote into preparing for and implementing each session. Consistent attendance helps honor the collaboration between clients and therapists and highlights the combined effort required to achieve therapeutic goals. Your signature below indicates your understanding of this policy and your commitment to receiving the full benefits of therapy.

Client Name: _____

Parent/Guardian Signature: _____ Date: _____