POINTS OF STILLNESS, LLC **PEDIATRIC INTAKE** **715.690.2600**

CLIENT INFORMATION:

Client Legal Last Name: _____First Name: _____Middle Initial: _____

Preferred Name: _____

Date of Birth: _____/_____/_____ Birth Sex: male/female Identifies as: male/female/non-binary

Pronouns: _____

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

Physician Name: _____ Clinic Name: _____

PARENT/LEGAL GUARDIAN INFORMATION:

NUMBER OF LEGAL GUARDIANS_____

Parent/Legal Guardian Name: _____ single/married/divorced/separated (circle)

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

Cell Phone: ( ) _____ Email: _____

Responsible for Medical Decisions? Yes/No (circle) If yes, are you 100% or 50% responsible for child's medical decisions.

If the child is living in separate households, you must provide a copy of any custody agreement including any medical & financial decisions.

Parent/Legal Guardian Name: _____ single/married/divorced/separated (circle)

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

Cell Phone: ( ) _____ Email: _____

Responsible for Medical Decisions? Yes/No (circle) If yes, are you 100% or 50% responsible for child's medical decisions.

If the child is living in separate households, you must provide a copy of any custody agreement including any medical & financial decisions.

PLEASE LIST ANY ADDITIONAL LEGAL GUARDIANS ON SEPARATE PAGE

Is this child your: biological child/stepchild/adopted child/foster child (circle)

If not your biological child, at what age did they come into your home? _____

Primary language spoken in the home:_____ Languages exposed to:_____

INSURANCE INFORMATION:

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 _____/_____/_____

If at any time there is a change in your insurance benefits, it is your responsibility to notify the front desk. We cannot be responsible for back billing in these situations.

PLEASE PROVIDE ALL INSURANCE CARD(S) AND VALID PHOTO ID

I authorize the following therapy (check all that apply)

We will consult with you before including any of the therapy programs below.

_____ Occupational Therapy _____ Speech/Language Therapy _____ Light Therapy/Cold Laser

_____ Acuscope/Avazzia _____ Myopulse _____ AcuEnergetics®

_____ Craniosacral Therapy _____ Auditory Integration/Therapeutic Listening Protocols

_____ Sensory Processing Intervention _____Kinesiotape _____ Brain Activating Breathing

I ATTEST TO THE ACCURACY OF THE INFORMATION I PROVIDED ON THIS DOCUMENT.

_____ _____ _____

Parent/Guardian/Legal Representative Signature Relationship to Client Date

POINTS OF STILLNESS, LLC HUDSON, WI 54016 715.690.2600

CLIENT AUTHORIZATION: (PLEASE PRINT)

CLIENT FIRST NAME: _____ LAST NAME: _____

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 until services are discontinued.

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 the 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 social media, and presentations in workshops to other professionals or parents.
_____ 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:

Name:_____ Phone:_____ Fax:_____

Name:_____ Phone:_____ Fax:_____

Name:_____ Phone:_____ Fax:_____

I ATTEST TO THE ACCURACY OF THE INFORMATION I PROVIDED ON THIS DOCUMENT.

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

POINTS OF STILLNESS PEDIATRIC OT & SPEECH/LANGUAGE EVALUATION QUESTIONNAIRE:

CLIENT LAST NAME: _____ FIRST NAME: _____

PREFERRED NAME: _____

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/reasons for seeking an OT and/or speech and language evaluation?

_____

_____

_____

When was the concern first noticed? _____

_____

Has the concern/problem changed since it was first noticed? yes/no (circle)
If so, how? _____

_____

Is your child aware of the problem? yes/no (circle)
If yes, how did they feel about it? _____

_____

Do other family members have any speech, motor, cognitive, or other disorders/delays? yes/no (circle)
If yes, please describe: _____

_____

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

- ❑ psychologist/psychiatrist When? _____Where? _____
- ❑ occupational therapist When? _____Where? _____
- ❑ speech/language therapist When? _____Where? _____
- ❑ physical therapist When? _____Where? _____
- ❑ vision therapist When? _____Where? _____
- ❑ ENT When? _____Where? _____
- ❑ audiologist When? _____Where? _____
- ❑ neurologist When? _____Where? _____
- ❑ chiropractor When? _____Where? _____
- ❑ orthopedic surgeon When? _____Where? _____
- ❑ social worker When? _____Where? _____
- ❑ other:_____ When? _____Where? _____

FAMILY/SOCIAL:

Please describe the child's living situation at home (who resides in the home, any recent changes, etc.):

_____

_____

Does your child have siblings? yes/no (circle)
If so, what are their names and ages? _____
Who is the child's primary caregiver? _____

PREGNANCY AND BIRTH:

Please check if any of the following conditions were present during the mother's pregnancy with the child:

- ❑ high blood pressure
- ❑ anemia
- ❑ alcohol use
- ❑ bleeding
- ❑ water broke more than 24 hours early
- ❑ injury:_____
- ❑ illness:_____
- ❑ drug use:_____
- ❑ medications:_____
- ❑ operations:_____
- ❑ infections:_____
- ❑ unusual stressors:_____

Mother's age at delivery: _____
Length of pregnancy:_____

Check any that apply:

- ❑ cesarean section
- ❑ face presentation
- ❑ breech
- ❑ transverse (sideways)

Was medication given during delivery? yes/no (circle) If yes, please specify:_____
Was labor induced? yes/no (circle)
Was a forceps or vacuum extraction required? yes/no (circle)
Were there any complications during labor/delivery? yes/no (circle)
If yes, please specify:_____

Child's birth weight: _____
Did your child cry immediately after birth? yes/no (circle)

Please check if any of the following conditions were present in infancy with the child:

- ❑ seizures
- ❑ congenital defects
- ❑ meconium aspiration
- ❑ oxygen deprivation
- ❑ cardiac complications
- ❑ IV antibiotics
- ❑ NICU admissions
- ❑ syndromes
- ❑ jaundice
- ❑ transfusions
- ❑ tube feedings
- ❑ Infection(s)

Did your child require an extended stay after delivery? yes/no (circle)
If yes, please explain:_____

Was your child fed by: breast/bottle/other:_____ (circle)

HEALTH/MEDICAL INFORMATION:

Please list all current and past medical diagnoses related to the child's overall development: _____

_____

_____

Please check if any of these conditions were present in early childhood up to present day (if applicable):

- ❑ meningitis
- ❑ hepatitis exposure
- ❑ vision loss/glasses
- ❑ HIV
- ❑ hearing loss
- ❑ headaches
- ❑ measles
- ❑ sinusitis
- ❑ lead exposure
- ❑ lung difficulties
- ❑ scarlet fever
- ❑ TB exposure
- ❑ adenoidectomy
- ❑ seizures
- ❑ chronic ear infections
- ❑ chicken pox
- ❑ rubella
- ❑ thyroid disorder
- ❑ autism
- ❑ heart defect
- ❑ diabetes
- ❑ cystic fibrosis
- ❑ pneumonia
- ❑ acid reflux
- ❑ head injury
- ❑ frequent colds
- ❑ asthma
- ❑ learning disability
- ❑ tonsilectomy
- ❑ PE tubes
- ❑ high fever
- ❑ mumps
- ❑ encephalitis
- ❑ chronic strep
- ❑ other:_____
- ❑ unknown

Please list any/all hospitalizations or surgeries: _____

_____

Did your child pass their newborn hearing screening? yes/no (circle)
Has your child had a hearing exam? yes/no (circle)
If yes, list date and results:_____

Are immunizations up to date? yes/no (circle)
Any change or alteration in vaccine schedule? yes/no (circle)
If yes, please specify: _____

Known allergies? yes/no (circle)
If yes, please specify, including the reaction when exposed:_____

_____

Please list any medication(s), the dosage, and the reasoning for the medication: _____

_____

Known food sensitivities? yes/no (circle)
If yes, please specify, including the reaction when exposed:_____

_____

Does your child follow a special diet? yes/no (circle)
If yes, please specify: _____
Has your child ever suffered from a traumatic experience (i.e., death, divorce, accident, frequent moves, witness to violence, etc.)? yes/no (circle)
If yes, please specify:_____
Are there any concerns about physical, sexual, mental, or emotional abuse? yes/no (circle)
If yes, please specify:_____

My child currently sleeps/naps: inconsistently/well/restless/other: _____
Does your child snore? yes/no (circle)
Grind their teeth? yes/no (circle)
Sleep with mouth open? yes/no (circle

EDUCATION HISTORY:

Does your child attend daycare/school? yes/no (circle)
If so, list name of daycare/school and grade (if applicable): _____
Teacher's name: _____ Phone: _____
Times/days in school/daycare :_____

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

Does your child currently have an IFSP/IEP? yes/no (circle) 504 plan? yes/no (circle)
If yes, please provide a copy of the plan.

BEHAVIORAL/SOCIAL HISTORY:

My child (check all that apply):

- ❑ is social and engaging
- ❑ makes good eye contact
- ❑ listens well
- ❑ has tantrums
- ❑ understands safety
- ❑ has difficulty with transitions
- ❑ takes turns with peers
- ❑ has difficulties with attention
- ❑ plays well with others
- ❑ is oppositional
- ❑ has difficulty with separation
- ❑ is easy-going
- ❑ prefers to play alone
- ❑ has poor coping skills
- ❑ is sensitive to criticism
- ❑ is impulsive
- ❑ is destructive/aggressive
- ❑ is well-behaved
- ❑ is willing to try new activities
- ❑ is flexible with change
- ❑ dislikes new people/places
- ❑ is unable to self-calm
- ❑ quickly escalates without apparent cause

Activities/games/toys your child enjoys: _____
_____
Does your child prefer to do these activities alone or with other siblings/peers? _____

What motivates your child? _____

Does your child have more success interacting with adults than peers? yes/no (circle)
Does your child make and stay friends with peers easily? yes/no (circle)
If no, please explain: _____

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

_____

_____

_____

DEVELOPMENTAL MILESTONES:

If applicable, please list the approximate age that your child did the following: unknown (circle)

roll: _____	sit: _____	crawl: _____
walk: _____	finger feed: _____	use a spoon: _____
drink from a cup: _____	first word: _____	potty trained: _____

Emerging/Early Language Development:

Your child currently communicates using (check all that apply):

- ❑ eye contact/facial expressions
- ❑ body language (pointing, gestures, pulling person to desired object)
- ❑ signs
- ❑ sounds (vowels, consonants, grunting)
- ❑ single words
- ❑ phrases
- ❑ sentences
- ❑ augmentative and alternative communication (writing, pictures, device, app, etc.)

Does your child:

Repeat sounds, words, or phrases over and over?	❑ yes	❑ no
Initiate interaction with others to get needs met or to play?	❑ yes	❑ no
Take turns in games?	❑ yes	❑ no
Make appropriate eye contact with you?	❑ yes	❑ no
Follow your point or gaze?	❑ yes	❑ no
Understand what you are saying?	❑ yes	❑ no
Get your attention?	❑ yes	❑ no
Greet others appropriately?	❑ yes	❑ no
Identify common objects?	❑ yes	❑ no
Identify body parts?	❑ yes	❑ no
Identify pictures?	❑ yes	❑ no
Follow simple, one-step commands?	❑ yes	❑ no
Follow two-step, related commands?	❑ yes	❑ no
Respond appropriately to yes/no questions?	❑ yes	❑ no
Answer “wh” questions?	❑ yes	❑ no
Ask questions?	❑ yes	❑ no
Understand prepositions (in, on, under, etc.)?	❑ yes	❑ no
Understand color and size words?	❑ yes	❑ no
Show frustration when expressing their needs or wants?	❑ yes	❑ no

Later Language Development:

Understand stories read aloud or spoken to them?	❑ yes	❑ no
Answer fact-based questions about everyday events and stories?	❑ yes	❑ no
Answer inferential questions about everyday events and stories?	❑ yes	❑ no
Understand and use figurative language and sarcasm?	❑ yes	❑ no
Understand and interpret body language and environmental cues appropriately?	❑ yes	❑ no
Formulate language effectively to share ideas and tell stories?	❑ yes	❑ no
Follow multi-step directions in school and at home?	❑ yes	❑ no
Have difficulty with word-finding or retrieval?	❑ yes	❑ no
Experiences disfluencies/stutters while talking?	❑ yes	❑ no
Have difficulty with reading comprehension?	❑ yes	❑ no
Have difficulty with writing?	❑ yes	❑ no

Speech Sound Development:

Does your child have difficulty producing speech sounds? yes/no (circle)

If yes, please describe: _____

Approximately, what percentage of time do you understand your child's speech? 100/75/50/25/0 (circle)

Approximately, what percentage of time do ***others*** understand your child's speech? 100/75/50/25/0 (circle)

How does your child respond when not understood? _____

Voice:

Your child's rate of speech is:	❑ normal	❑ too fast	❑ too slow
Your child's vocal volume is:	❑ normal	❑ too loud	❑ too quiet
Your child speaks in a pitch that is:	❑ normal	❑ too high	❑ too low

Other/comments about your child's speech/language skills: _____

_____

_____

FEEDING/ORAL MOTOR DEVELOPMENT:

Does your child demonstrate difficulty with any of the following? (Check all that apply)

- ❑ choking/gagging
- ❑ food or liquid coming out of the 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 checked above: _____

_____

_____

_____

_____

How does your child take most liquids? bottle/sippy-cup/straw/open-mouth cup/other: _____ (circle)

How much does your child usually drink per day? _____

Does your child feed themself? yes/no (circle) If yes, what did they 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: _____

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

❑ poor ❑ fair ❑ good ❑ excellent ❑ too much

Who usually feeds your child? (Check best answer)

❑ mother ❑ father ❑ caregiver ❑ themself

Is there a difference in eating patterns depending on who feeds your child? yes/no (circle)
If yes, please describe: _____

Does your child demonstrate any of the following during mealtime? (Check all that apply)

- ❑ throws food
- ❑ refuses to eat
- ❑ leaves the table before finishing
- ❑ spits food
- ❑ messy eater
- ❑ takes food from others' plates
- ❑ cries/screams
- ❑ walks around while eating
- ❑ overstuffs mouth

Do your child's food preferences and habits match that of the family? yes/no (circle)
If no, please explain: _____

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

❑ < 10 min. ❑ 10-20 min. ❑ 20-30 min. ❑ 30-60 min. ❑ >60 min.

Please circle the appropriate response:
Are mealtimes a pleasant experience? yes/no
Does your child mind being touched in/around the mouth? yes/no
Does your child sleep with a bottle or cup? yes/no
Does your child use a pacifier? yes/no
Does your child suck their thumb, fingers, or objects? yes/no
Does your child drool? yes/no
If yes, indicate how often: ❑ rarely ❑ occasionally ❑ frequently ❑ Constantly

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.)				

Please circle the appropriate response:
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
Does your child resist having their teeth brushed? yes/no
Have you noticed any bleeding or foul odor in your child's mouth? yes/no

TECHNOLOGY USE:

Please make every effort to think about and honestly estimate the amount of time your child spends on screens in an average day. _____hours per day
Does your child have their own smart phone or tablet? yes/no (circle)

What type of recreational or social apps and technologies does your child use (Twitter, Facebook, SnapChat, YouTube, e-mail, video games, etc.)? _____
_____
Please list any video games your child plays:_____

SENSORIMOTOR HISTORY:

Please think of the various stages of your child's development, considering behavior that comes to mind as you answer these questions. What do you think of as being different from other children you know? Were there times when your child's behavior was difficult to cope with in the family unit? The following questions are posed to help in compiling a more complete picture of your child from early infancy to the present developmental stage. Some of the questions may refer to children who are older. Kindly cross out the verb tense that does not apply. Check the choice that applies: Yes, No, Used to, or N/A (not old enough yet or for other reasons not applicable). Add narrative information that would also be important on the side/back. Thank you for your assistance.

Auditory (Sound)

Does (is) your child...	Yes	No	Used to	N/A
Hypersensitive to sounds				
Fear of unexpected noises				
Fear of unusual sounds				
Distracted by sound				
Miss sounds or words				
Have trouble listening				
Have trouble locating sound				
Make loud noises				
Sing/dance to music				
Have trouble imitating rhythmic sounds				
Cover ears to block sounds				
Talk excessively				
Talking interferes with listening				

Visual

Does(is) your child...	Yes	No	Used to	N/A
Have a visual problem				
Seem very sensitive to light				
Have trouble using eyes				
Avoid eye contact				
Distracted by visual input				
Dislike eyes covered				
Able to close eyes for short periods				
Make reversals when writing, copying, or reading				
Avoid sunlight				
Have trouble with shapes, colors, or size				
Squint often				
Able to look far away				
Able to look close				
Use 2 eyes together				
Look to side or down to see things close up				

Vestibular/Proprioception (Movement/Gravity/Muscle and Joint Activity)

Does your child...	Yes	No	Used to	N/A
Arch back when held or moved				
Enjoy being rocked				
Like being tossed in the air				
Like fast rides				
Like to swing				
Spin or whirl more than other children				
Get carsick easily				
Get nauseous and/or vomit from other kinds of movement				
Rock/bounce while sitting				
Jump a lot				
Have fear in space (stairs, heights)				
Lose balance easily				
Walk on toes (not on whole foot)				
Misunderstand meaning of words used in relation to movement or position				
Enjoy upside-down play				
Like to jump from steps or heights				
Like to climb				
Like to push/pull heavy things				
Like to hang from doorknobs, play equipment, woodwork, etc.				

Coordination

Does(did) your child...	Yes	No	Used to	N/A
Sit, stand, or walk late				
Sit, stand, or walk early				
Omit or shorten the creeping/crawling phase				
Have a very long creeping/crawling phase				
Make slow movements (plodding deliberate)				
Play with toys appropriately for age				
Have trouble with dressing, buttoning, zipping, or shoe tying				
Play with toys clumsily				
Have trouble holding pencil correctly				
Creep on tummy or bottom				
Trip or fall a lot				
Seem awkward				
Bump into things				
Have a definite hand preference: _____				
Have poor handwriting				
Handle small things easily				
Eat neatly for age				
Have rigid movements				
Grimace or use tongue in fine motor tasks				
Shake during fine motor tasks				
Like sports, phy ed				
Have many ideas of what to play				

Tactile (Touch)

Does your child...	Yes	No	Used to	N/A
Like to be touched				
Dislike being held or cuddled				
Prefer to touch rather than be touched				
Seem excessively ticklish				
Seem easily irritated or enraged when touched by siblings or playmates				
Have a strong need to touch people and objects				
Seem to pick fights				
Pinch, bite, or otherwise hurt self or others				
Frequently bump or push others				
Bang head on purpose				
Like to touch animals				
Dislike the feeling of certain clothing				
Over or under dress for the temperature				
Overheat easily				
Seem overly sensitive to food and water temperature				
Seem overly sensitive to rough food textures				
Prefer tub baths over showers				
Like to play in water, sand, mud, clay, etc.				
Seem to lack the normal awareness of being touched				
Often seem unaware of cuts, bruises, etc.				
Avoid using hands				
Examine objects or clothes with hands				
Mouth objects or clothes excessively				

Taste and Smell

Does(is) your child...	Yes	No	Used to	N/A
Act like all food is the same				
Explore with taste				
Chew on non-food items				
Hypersensitive to smells				
Taste or smell toys, clothes, or foods more than usual				

Muscle Tone

Does your child...	Yes	No	Used to	N/A
Feel heavier than looks				
Have good endurance				
Have a muscle problem				
Have flat feet				
Slump when sitting				
Get tired easily				
Seem weak				
Keep mouth open				
Seem stiff				

Learning Styles

Does (did) your child...	Yes	No	Used to	N/A
Recognize own errors				
Learn from mistakes				
Acquire materials for task independently				
Able to set up workspace				
Maintain workspace				
Generalize known skills to new ones				
Have age-appropriate memory				
Ask for help when necessary				
Plan ahead				
Create new ideas, new ways of doing things				
Use age-appropriate content in written language				
Get work done on time				
Average reading level				
See possibilities for exploration play in the environment				
Use trial and error to problem solve				
Exhibit curiosity				

Adapted from “Sensorimotor History” by Oetter, 1986; revised 2005.

POINTS OF STILLNESS, LLC
2705 Enloe St, Hudson, WI 54016
Phone: 715-690-2600
Fax: 715-381-8131
info@pointsofstillness.com
Occupational & Speech Therapy
Wellness Programs for Children and Adults

Teletherapy Consent Form

Client Name:_____

Date of Birth:_____

Location of Patient: Patient **MUST** be in the states of Wisconsin or Minnesota to receive teletherapy services. (Point B)

Therapist Name: Occupational or Speech Therapist staff of Points of Stillness (Point A)

Physical Office Location: 2705 Enloe Street, Hudson, WI 54016

I understand that teletherapy is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to a therapist providing occupational or speech therapy services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that the designated therapist will be the only one present during the teletherapy session (Point A). Caregivers, the client, and other family members may be present during teletherapy session (Point B).

I understand that teletherapy video information will not be stored or forwarded to anyone else.

I understand that written documentation will be kept for records per usual format.

I understand that I will be responsible for any copayments or co-insurances that apply to my telemedicine.

I understand that I have the right to withhold or withdraw my consent to the use of teletherapy in the course of my care at any time without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting *Points of Stillness* at 715-690-2600 or **info@pointsofstillness.com**

As long as this consent is in force (has not been revoked) a staff therapist may provide occupational or speech therapy services to me via teletherapy without the need for me (or my minor child) to sign another consent form.

Signature of Client (or person authorized to sign for patient):

_____ **Date:**_____

If authorized signer, relationship to patient:_____

I have been offered a copy of this consent form (initials):_____

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 24-hour notice prior to missing an appointment and failure to attend the scheduled appointment. A charge of $50 for each no-show episode will be charged to your credit card.

· 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 5 minutes before 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 (>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/Legal Representative Signature _____ Date: _____

POINTS OF STILLNESS, LLC

QUESTIONAIRE FOR CLIENTS WITH PARENTS/LEGAL GUARDIANS THAT SHARE CUSTODY

Please complete and return this questionnaire to the front desk. Be advised that any changes occurring during the course of the year should be brought to the attention of Points of Stillness, LLC. It is the custodial parents' responsibility to inform Points of Stillness, LLC of any changes in custody/visitation rights.

Client Name(s):

_____ _____

_____ _____

Parent/Legal Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Type of Action (divorce, separation, annulment, custody dispute, support dispute): _____

Current Status of Action: _____

County in which action is filed: _____

Name(s) of other parent/legal guardians:

Name: _____ Phone: _____

Email: _____

Name: _____ Phone: _____

Email: _____

Is there a Court Order dealing with custody/visitation: Yes/No

Are you the custodial parent/legal guardian? Yes/No

Is there a joint custody order? Yes/No

Are you the residential parent/legal guardian? Yes/No

Are there any court orders curtailing or restricting the rights and privileges of any parent/legal guardian with respect to his/her right to be kept informed of the medical status and therapies or to participate in those therapies? Yes/No

Do you have a court order that specifically states that the other parent/legal guardians cannot pick up the client from Points of Stillness, LLC? Yes/No

NOTE: If you answered yes to any of the above questions, you must attach a certified copy of the applicable portion of any such court order pertaining to the previous questions.

Signature: _____ Date: _____

Points of Stillness, LLC
2705 Enloe Street
Hudson, WI 54016
715-690-2600
info@pointsofstillness.com

REQUIRED AT FIRST VISIT

Points of Stillness requires clients to keep a credit card on file to pay any balance due after insurance has made payment to us (this includes both primary & secondary insurance companies). This card will be used only to charge any outstanding balance due on the patient's account (co-payments, co-insurance amounts, deductibles, and non-covered services) that have not been paid within 60 days or if payment has not been received after 2 statements have been sent to you from Points of Stillness, LLC.

We will not accept HSA/HRA cards for this form. You are welcome to use your HSA/HRA card to pay your bill by calling or stopping at the front desk, paying by using your private client portal, or paying online from your emailed invoice.

Along with your credit card, we will need a copy of your valid photo ID.

Our office is fully committed to providing appropriate security of our records (including your credit card number), protecting the privacy of our patient's information, and properly maintaining our billing policies in accordance with national HIPAA standards.

Why does Points of Stillness keep my credit card on file? This is becoming the "norm" for medical practices just as it is when you check into a hotel. By being able to charge the remaining balances on the credit card for people who don't pay their bills within 60 days or 2 statements, we are able to keep our costs lower, continue to provide you great care, and pay our hard-working staff. Being a small practice, it is important for us to try and always keep your costs low and keeping a credit card on file allows us to do this.

Is my information secure? Absolutely! The information is stored in our HIPAA compliant billing software and only billing staff have access to it.

Will I have the opportunity to pay my bill? Yes! Once your insurance company has paid their portion, you will receive your bill by email, with your balance due. You can also set up a Points of Stillness client portal account where you can access your billing information and pay at any time. (Please stop by the front desk to set up your private client portal account.) You have the option to pay your invoice by check, credit card or cash. Our policy is that we send two statements. Statements are send at the beginning of each month. If after that time the bill has not been paid, the credit card will be charged.

What if there is an error, or a charge, I want to dispute? You still have the opportunity to dispute any charge with your credit card company as you would for any other charge. Also, our billing office is available by phone to answer any questions about your bill or any credit card charges.

My insurance always pays for everything so why do I need a credit card on file? There are virtually hundreds of different plans, and we cannot know the intricacies of every patient's plan until the claim has been sent. If there is a zero balance, then your credit card information will just remain securely stored and never charged.

I understand all of the above but I either don't carry credit cards or am just not comfortable with this policy? While every rule has an exception, we ask that in this case you fill out an authorization form which would allow us to transfer money from your bank account to ours. This money will be applied to your balance.

What if I have Medicaid? This card will be used for non-covered services, such as supplies, or if your insurance coverage lapses.

This card will only be charged after all these conditions have been met:

- **primary insurance has paid**
- **secondary insurance has paid**
- **2 client statements have been sent to client or guardian and not paid within 60 days**

For questions, please call our billing department Monday – Friday, 8:00 am to 4:00 pm. They will be happy to assist you.

Points of Stillness, LLC
2705 Enloe Street
Hudson, WI 54016
715-690-2600
info@pointsofstillness.com

Credit Card Payment Authorization Form (required at first visit)

Client Information:

Client Name:_____

Street:_____

City:_____State: _____Zip:_____

Phone: ( ) _____-_____

Email:_____

Payment Information:

I authorize Points of Stillness, LLC to automatically bill the credit card listed below as specified:

Credit Card Information: Card Type (Circle One): Mastercard Visa Discover American Express

Name:_____

Card Number:_____

Expiration Date: _____/_____ CVV _____ Credit Card Billing Zip Code:_____

_____Notify me via email when my credit card is charged. (Make sure email address above is correct.)

Cardholder Signature: _____Date:_____

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 used 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 your 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 your 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 your 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.