Where function and movement meet to make Amazing Achievements.

Participant Handbook

Participant/ Parent Handbook

Mailing Address: 6604 Shire Lane,

Wilmington, NC

Office Phone Number: 708-712-1200

Programs Offered:

Occupational Therapy: This program helps children improve their ability to perform functional activities, and or learn how to compensate to increase their independence of play, daily living and self-help skills such as grooming, bathing, dressing and feeding so that they can fully participate in home, school and community activities. Occupational therapy also works on developing functional and developmental milestones, executive functioning, fine motor coordination, handwriting, visual motor function, core and upper body strength and sensory processing and regulation, along with emotional regulation. Many other benefits that have been achieved, since this special Occupational Therapy program focuses on the child as a whole, are an improvement in body awareness, comprehension and communication, both verbally and non-verbally, social skills , improving gross motor skills and reaching developmental milestones including but not limited to sitting, standing, crawling, walking, jumping and running, increasing core strength, flexibility, balance, endurance and coordination so that they can achieve their highest level of functional independence.

For all patients and participants:

- There may be a time when riding the horse is no longer an appropriate option. This could be based on, but is not limited to age, weight, height, behavior, medical condition and independent ability level. These limitations are set to ensure safety of all involved including the participant, the horse, and the staff and volunteers.

These decisions are carefully and thoughtfully discussed by all managers at the Occupational Therapy location. The final determination of safety and ongoing participation with the horse is up to the discretion of managerial staff.

Prior To Your First Visit:

- All paperwork must be completed before the first therapy evaluation.
- Please keep a copy of your paperwork.

When You Arrive:

- Please arrive a few minutes early. Every effort is made to start sessions on time. Session time includes pre and post mounted activities.
- Fees are due prior to each therapy session and must be arranged prior to the start of each therapy session.

While on the Property:

- Parents/ caregivers are to remain on the premises during therapy sessions. Parents/caregivers will be solely responsible for the participant before and after therapy sessions.
- Please wait in the participant waiting area located in front of the barn area and a staff member will greet you in the waiting area to begin your session.
- All children not riding must be supervised by an adult at all times.
- There is no smoking on the property.
- No guns, knives weapons or violence of any kind are allowed on the premises. This is a zero tolerance rule. Violators will be asked to leave and not allowed to return.
- No dogs are allowed on the property. (Service animals are welcome.)

Payment Information & Insurance {For Therapy Services):

- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made a payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment, is responsible for full payment at the time of service.
- Regarding missed appointment(s) and cancellations: Our goal is to provide the best services to our participants. Therefore, we require at least a 24 hour notice for cancellations, or for re-scheduling your appointments.

***There will be a $50.00 no show fee or cancellation fee if not canceled more than 24 hours. These fees are NOT covered by insurance.**

If you need to cancel a session please call 708-712-1200 If Jennifer Davis needs to cancel every effort will be made to re-schedule the session at the convenience of the participant. We reserve the right to assess a fee for missed and no show/no call appointments. Multiple failed appointments may result in being dismissed from our program.

For Your Safety:

Dress:

All participants are required to wear an ASTM-SEI helmet to ride; or an alternate therapeutic helmet if appropriate, selected by the therapist. There are some available on-site, such as Amazon.

Bike helmets will NOT be allowed.
Helmets must be approved at the beginning of the session.
Helmets must be worn at all times during the lesson or therapy session.

Participants are required to wear long pants/breeches for all riding lessons. Lesson participants will not be permitted to ride in shorts. Closed toe shoes or boots with a low heel are mandatory for all mounted activities. No sandals or ballet flats are allowed in the barn or arena. Parents and siblings wearing sandals or ballet flats are allowed in the viewing room area and therapy center only.

All riders must wear shoes. No one will be allowed to ride or be around the horses if they are barefoot, in ballet flats or in sandals.

Please dress for the weather.

Summer:

Lessons: Avoid pants that can be converted into shorts. The seam is very irritating and makes it difficult for the participant to grip with the legs. No spaghetti strap tank-tops, shorts, skirts, sandals, halter tops, shortened tops and clothing too loose to maintain safety in the riding environment will be allowed.

Sunscreen and bug spray are a good idea.

Therapy: Please wear clothing that is comfortable and allows for stretching and maximum range of motion. Skirts and dresses are not ideal for the positions the rider may be in while on the horse.

Winter:

Please wear gloves. A headband will fit comfortably under the helmet and provide warmth. Bulky hats that do not fit under the helmets will be removed. Avoid nylon pants as they are very slippery and make it difficult to maintain a participant's position on the horse.

General Safety:

- For training and safety purposes we ask that volunteers and participants NEVER HAND FEED THE HORSES.
- Only the participant, therapist and staff/volunteers are allowed in the dirt portion of the arena. There is a special section in the far corner where others can sit to observe.
- Participants/visitors must be accompanied by a staff member or volunteer to enter the stall area.
- Hitting or kicking of horses is NEVER allowed and will result in dismissal from the program. The same for DURING any portion of the session. That portion of a session will immediately stop and that time will count as treatment time and not be adjusted for that session, for respect of the following participant's time to start on time.
- Please do not climb or lean on any fences, gates or doors.
- In order to ensure the safest riding conditions we ask that children and visitors refrain from screaming, running, or ball playing on the premises. (Unless under the direction of a therapist.)
- Due to HIPPA laws only staff and participants are allowed in the therapy room unless the therapists states otherwise. Thank you!!!

Falls From Horses:

Staff is in charge of the situation. Horse handlers will halt all horses and will supervise their participant. The instructor will determine the immediate needs of the fallen participant and act accordingly such as call 911, provide first aid, remount, or whatever is appropriate.

Weather:

We reserve the right to cancel or shorten lessons /sessions due to weather conditions. Every effort will be made to contact participants in a timely manner if lessons /sessions are canceled. Please call the office if you are unsure.

Cold: In situations of extreme cold the facility may be closed and all sessions canceled. In other instances, the arena may be closed and the therapy center will still open for other portions of the sessions.

Heat: When the temperature reaches dangerous levels for either the participants or the horses. We reserve the right to cancel portions of the treatment session if the temperature or humidity is believed to be too much for the participants, horses, staff and volunteers.

Storms: Thunder, high winds, rain, or hail may abruptly end a session or postpone/alternate or exclude some portions of a session until the storm has passed.

Sick Participant Policy:

In an effort to ensure a healthy environment at please call the office at as soon as possible to reschedule your reserved appointment ***time if YOU or YOUR CHILD exhibits any of the following symptoms: While these guidelines seem severe we must protect everyone during this time with COVID.***

1. **Too sick to attend work or school.**
2. **Fever or vomiting. You or your child and all individuals exposed to the child must be symptom free for 14 *days* prior to the scheduled appointment time.**
3. **Green or yellow discharge from the nose.**
4. **Display of any other symptom in accordance with health department regulations (CDC).**

If you/your child attend a session and display symptoms of sickness we reserve the right to halt treatment and bill for time with child and/ or charge a fee.

Participant Appointment & Financial Policy:

Thank you for choosing to participate in Occupational Therapy, Jennifer Davis, OTR/L Amazing Achievements Occupational Therapy, PLLC, We are committed to providing you with the highest quality services.

Please note: Payment is due at the time service is provided unless other arrangements are made in advance. Our office accepts cash, personal checks, and Zelle.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee.

Regarding Insurance:

- As a courtesy to you, we will help you process all of your insurance claims if applicable. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, service limits and maximums which are your responsibility. Please contact your insurance company for details on your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as the billing entity, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our program is committed to providing the best treatment for our participants and we charge what is usual and customary for our area unless otherwise negotiated. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, or Zelle at the time we provide the service to you.

Dismissal Policy:

PATH International and AHA standards

Portions of Occupational Therapy provided by Jennifer Davis, incorporates the farm, farm animals, clinic room and values the safety and the quality for each participant and their visitors. The following guidelines have been established to insure all participants, guests, volunteers, horses and employees are treated with care and consideration for their safety. The program staff, on behalf of Occupational Therapy, Jennifer Davis, OTR/L, Amazing Achievements Occupational Therapy, PLLC, reserves the right to be the sole authority in determining a participant's appropriateness for the program. All participants will be given one warning with the exception of violations that endanger the health or welfare of our participants, volunteers, visitors, staff or horses. Each participant will be given individual consideration. The following list is intended to give you notice of reasons for participant dismissal. However, it does not include every type of unacceptable behavior or event that can or will result in a participant's dismissal from the Occupational Therapy program. The Occupational Therapy program reserves the right to dismiss any participant as it sees fit in its sole and absolute discretion.

- Any participant who has achieved a level of skill which is appropriate for integration into a regular riding program will be assisted by the instructor, to be transitioned Into a traditional or adaptive riding lesson which will meet their needs.
- Any participant who has a significant change in medical status which negates their appropriateness for the program.
- Participants who exhibit or possess any of the contraindications specifically listed in the current edition of the PATH International Standards Manual Chapter on Precautions and Contraindication to Therapeutic riding may not be accepted for riding.
- Riding causes a decrease in the participant's physical or psychological functioning.
- Participants who exhibit inappropriate or uncontrollable behavior, which places the participants, volunteers, staff, spectators or horses in an unsafe situation will be asked to leave the premises and may be asked to withdraw from the program.
- Participants who exceed the prescribed weight guidelines may at the discretion of Dream Riders be dismissed. A participant who is not able to sit astride a moving horse will be evaluated on an individual basis for participation.
- Participants who are able to sit astride a moving horse and whose weight exceeds 175 pounds will be evaluated on an individual basis for participation.
- We cannot provide an appropriate mount, volunteers or equipment to meet the participant's needs.
- Failure to comply with payment schedules or subsequent payment schedules will be requested to withdraw from the program.
- Participants who have multiple unexcused absences may be asked to withdraw from the program.
- Participants who wear any of the following prohibited clothing will not be allowed to ride that day. Repeated offenses may jeopardize their riding slot: shorts, skirts, sandals, halter tops, shortened tops, and clothing too loose to maintain safety in the barn/riding environment.
- Visitors, spectators or family members who do not conduct themselves in a manner appropriate to the facility will be asked to exit the premises and may jeopardize the riding experience for their participant.

Emergency Procedures:

Emergency, Medical, Fire, Police.....911

Poison Control Center .....{800)222-1222

If You See Smoke or Fire Within or Coming From Any of the Buildings:

1) Call or have a staff member call 911. Give them the address and phone number as shown on the bottom of this paper.
2) Notify a staff member.
3) Evacuate the building from which smoke/fire is coming if necessary and possible.

In Case of a Medical Emergency:

1) Call or have a staff member call 911.
2) Notify a senior staff member who will notify injured/ill party's relations.
3) In the event of a possible injury to neck or back, move the person only if they are in immediate danger where they are. Stabilize the neck and back as best as possible prior to moving. Do not move if possible.
4) Stabilize the injured person using appropriate first aid procedures and make them as comfortable as possible.
5) Stay with the person until help arrives.
6) File a written report with the administrator or director as soon as possible.

Tornado /Severe Storm:

1) Staff members are responsible to account for patients and patient's families and direct them in the emergency procedures. Take a head count of everyone within the building.
2) Staff will instruct what to do and Staff should give assistance to those with special needs. Repeat the head count once you are in the sheltered location.
3) If there is insufficient time or weather conditions (hail, blinding rain, etc.) make it unsafe to leave the building you are in, go to an interior room without windows if possible, and lay flat on the floor until the storm has passed.
4) Stay away from window or other objects that could become dangerous debris in the high winds. Stay away from the power lines that could fall during the storm.

Acknowledgement and Receipt of the Occupational Therapy Participant Handbook

I acknowledge that I have received a copy of the Occupational Therapy Participant Handbook. I understand that it contains important information on policies and procedures. I realize this handbook is not intended to cover every situation that may arise, but is a general guide to refer to.

I understand that it is my responsibility to familiarize myself and my child(ren) with the information and I agree with the policies and rules of the program.

I further understand and acknowledge that the Occupational Therapist may change, add or delete any policies or provisions in this handbook as they see fit in its sole judgement and discretion.

I acknowledge and understand that this handbook supersedes and replaces any and all prior handbooks or materials previously distributed.

Participant's Name(s):_____ Date:_____

Parent/Gardian Name (please print) _____

Parent / Guardian SIGNATURE: _____

Your Rights:

Right to Inspect and Copy: You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to **Jennifer Davis, OTR/L, HPCS, Amazing Achievements Occupational Therapy, PLLC,6604 Shire Lane, Wilmington, NC 28411** We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health care record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format your request; if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of Breach: You have the right to be notified upon a breach of any of you unsecured Protected Health Information.

Right to Amend: If you feel the Health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request, in writing, to **Jennifer Davis, OTR/L, Amazing Achievements Occupational Therapy, PLLC, 6604 Shire Lane, Wilmington, NC 28411.**

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your, in writing, to Jennifer **Davis, OTR/L, HPCS, Amazing Achievements Occupational Therapy, PLLC, 6004 Shire Lane, Wilmington, NC 28411.**

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse.

To request a restriction, you must make your request, in writing, to **Jennifer Davis, OTR/L, Amazing Achievements Occupational Therapy, PLLC, 6604 Shire Lane, Wilmington, NC 28411.** We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-Of-Pocket Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to **Jennifer Davis, OTR/L, HPCS, Amazing Achievements Occupational Therapy, PLLC, 6604 Shire Lane, Wilmington, NC 28411** your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice from Jennifer Davis, your therapist. To obtain a paper copy of this notice, you must make your request, in writing, to **Jennifer Davis, OTR/L, HPCS, Amazing Achievements Occupational Therapy, PLLC, 6604 Shire Lane, Wilmington, NC 28411.**

Changes to This Notice: We reserve the right to change this notice and make the new notice apply to Health information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

BENEFITS SUMMARY STATE

Date:_____ Insurance Co_____

Patient Name:_____ Subscriber name:_____

ID No. _____Group#: _____ **Effective Date.**_____

0 IN-NETWORK O OUT-OF-NETWORK O ACTIVE O INACTIVE

OCCUPATIONAL THERAPY

Authorization Required: YES NO

REVIEWED BENEFITS WITH PATIENT/PARENT/GUARDIAN: (YES/ NO) Date:

Member name: _____ **Date of birth:** _____

ID Number: _____ **Group Number:** _____

Secondary Insurance: **None** **Commercial** **Medicaid** **Private Pay**

Insurance Co.Name: _____ **Insurance Phone Number:** _____

Desired Days & Times: _____

Referred by: _____

Patient Name: **Date of Birth:** _____

Parents Name/s: _____

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

Home: _____ **Cell:** _____

Email:

Current Therapies if any and frequencies: _____ **Diagnosis:** _____

Down syndrome diagnosis: **do you have the X-Ray cervical spine clearance? ___Y_____N (need to get this before scheduling)**

Approximate Height & Weight: _____

Precautions **(g-tube, seizures, surgical implants/rods/pins,etc.):** _____

Special Requirements: **Walk up 3 steps?____Yes____No** **Wheelchair Mount Needed?** **Yes** **No**

Primary Care Physician's Name & Phone Number ----------

Sent Packets On: _____

Participant Medical History

(To be completed ONLY by PHYSICIAN)

Name: ---------- DOB:----------
Address:----------

Name of Parent/Guardian_____

Diagnosis (and ICD9#): ----------

For Persons with Down Syndrome: Atlanto Dens Interval X-Rays Date:_____ Results: Pos Neg

Neurological Symptoms of Atlanto Axial Instability:----------

Past/Prospective Surgeries:----------

Tetanus Shot: Yes No Date:_____ Height:_____ Weight:____

Shunt Present: Yes No Date of last revision:_____

Seizure Type:_____ Controlled: Yes No Date of last seizure _____

Medications:

_____

_____

Mobility Independent Ambulation: Yes No Crutches: Yes No Braces: Yes No Wheelchair: Yes No

Special Precautions/Needs:_____

Please indicate if participant has a problem and/or surgeries in **any of the following areas by commenting yes or no. If yes, please explain.**

Auditory_____
Visual_____
Speech_____
Cardiac_____
Circulatory_____
Pulmonary_____
Neurological_____
Muscular_____
Orthopedic_____

Physician Signature:_____

*Please complete next page**

Physician's Statement

To my knowledge there is no reason why this person can not participate in skilled therapy, incorporating the use of evidenced based practice of equine movement in their sessions.
However, I understand that the therapist will weight the medical information above and the existing medical precautions and contraindications.

Physician Name (please print):

Phone: **Fax:** **Date:**

Address:

Physician Signature:

Waiver and Release

Read Thoroughly Before Signing

Note: A separate form must be signed for each participant.

Important Information: Participants and parents/guardians of minors/wards in activities offered at or from the entire property that is being used by Amazing Achievements occupational Therapy, PLLC (the site), or by or associated with any of the "Parties"
(described below) recognize that there is an inherent risk of injury when choosing to participate in the activities (including use of equipment and property). You are solely responsible for determining if you or your minor child/ ward is physically fit and/or adequately skilled for the activities contemplated by this agreement. It is always advisable, especially if the participant is pregnant, disabled in any way or has recently suffered an illness, injury or impairment to consult a physician before undertaking any physical activity.

Warning of Risk: Activities are intended to challenge and engage the physical, emotional and/or mental resources of each participant. Despite careful and proper preparation, instruction, medical advice, conditioning and equipment, there is still a risk of serious injury when participating in any offered activity. All hazards and dangers cannot be foreseen.

Depending on the particular activity, certain risks, dangers and injuries may exist due to inclement weather, slips and falls, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, premises defects, inadequate or defective equipment, inadequate supervision, instruction or officiating, and other risks inherent to the particular activity. In this regard, it is impossible for any party to guarantee absolute safety.

Parties: The "Parties" to which this waiver, release and authorization extend to include Jennifer Davis as acting Occupational Therapist Jennifer Davis, OTR/L, Amazing Achievements Occupational Therapy, PLLC, SpiritHorse Therapeutic Riding Center and surrounding property and any and all owners of the Site and improvements located thereon; any provider, or person involved in providing, any activity, the limited liability company members and managers, shareholders, directors, officers, employees, agents, and volunteers of the all previously referenced entities or persons, and their heirs, estates, representatives, successors and assigns.

Waiver and Release of All Claims and Assumption of Risk: Please read this form carefully and be aware that in signing up and participating in any offered activity, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your minor child/ward might sustain as a result of participating in any and all activities connected with and associated with the Site and/or activities offered by or through any Parties listed herein, or with use of any property or equipment loaned to you or associated with such activities (included but not limited to transportation services, operation and/or use of Four Wheel All-Terrain Vehicle, Gold Cart, Motorized Farm Equipment, or other vehicle; or medical, therapy or equipment on property; when provided). Use of or loan of the following such equipment or property is specifically acknowledged:

Under the Connecticut Equine Activity Liability Act, Chapter 925, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss or damage to persons or property resulting from the risk of equine activities. I recognize and acknowledge that there are certain risks of physical injury or death to participants in activities, and I voluntarily agree to assume the full risk of any and all injuries, death, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said participation. I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of participating in any activity, against all persons and entities named herein or associated with such activities, (against, the "Parties").

Waiver and Release

I have read and fully understand the above important information, authorization, warning of risk and waiver and Release of all claims.

Note: A separate form must be signed for each participant

PLEASE PRINT

Child/Ward's Name:----------

Child/Ward's DOB:----------

Parent/Guardian Signature:----------

Print Parent/Guardian Name: ----------

Address:----------

PLEASE PRINT

Witness Signature:----------

Print Witness Name: ----------

By initialing here it is acknowledged that the above Child/Ward/Participant intends to participate in activities on multiple dates in the next 12 months, and it is expressly agreed that this Waiver and Release extends to each such visit and to all activities in which participation is had at all visits. {If not so initialed, a new Waiver and Release must be completed and signed at each visit.)----------

HIPAA Notice of Privacy Practices

This notice describes how medial information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our Obligations: We are required by law to:

- Maintain privacy of the protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How we may use and disclose health information: The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Administrative Department.

For treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved with your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Options: We may use and disclose Health Information for the health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure that the therapy you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or close friend. We may also notify you family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information, for research the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We may also release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licenser. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access or to disclosure of your health information.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Uses And Disclosures That Require Us To Give You An Opportunity To Object And Opt:

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Your Written Authorization Is Required For Other Uses And Disclosures:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Uses and disclosures of Protected Health Information for marketing purposes; and 2.Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Administration Department and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on you authorization before you revoked it will not be affected by the revocation.

HIPAA Acknowledgment and Consent Form

I understand that under the Health Insurance Portability and Accountability ACT of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounding to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name:_____ DOB: (mm/dd/yy)_____

Signed (Patient or Legal Representative for

Patient)_____

Date: _____

Legal Representative's Relationship to

Patient:_____

Seizure Protocol Form

(Complete this form only if applicable)

Seizure Type: ----------

Date ofLast Seizure:_____

Medications taking:----------

Frequency of Seizures: - - - - - - - - - - - - - - -

What do the seizures look like? ----------

If you or your child has a seizure while at Jennifer Davis, OTR/L, Amazing Achievements Occupational Therapy, PLLC are there any special actions or procedures you would have us follow?

Participant/Parent/Guardian Signature: ----------

Print signature:----------

Date:_____

***Please note: We are not able to administer medications. If a seizure occurs while the participant is participating in Occupational Therapy and a parent is not available or on site, we reserve the right to call emergency services.

Intake

Food Permission/Dietary Information and Item/Food Contact

Patient's Name:_____

Please complete the following to inform staff of your child's diet restrictions and to allow your child to participate in snack activities and/or touching/playing with particular foods or items such as, to name a few, shaving cream, toxic free finger paint, glue, play dough. .....SNACK TIME WILL BE USED AS A GENERIC DESCIPTION OF ABOVE MENTIONED.

_____My child may participate in snack time and has no dietary restrictions

_____ My Child may participate in snack time if dietary restrictions are observed Diet

Restrictions:

_____ My child may participate in snack time, however, I will provide his-her snack for snack time.

_____My child should not participate in snack time.

Please list the foods your child is motivated to eat:/ sensory play:

Parent/Guardian Signature_____ Date_____

Intake

Occupational Therapy Jennifer Davis, OTR/L, HPCS Amazing Achievements Occupational Therapy, PLLC, 6604 Shire Lane, Wilmington, NC 28411

Patient Payment Plan

I, ----------, the patient, (Account#_____) understand that I am agreeing to the following payment plan between myself and Dream Riders. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the timeframe listed below. All unpaid balances 30 days or older will be considered for third party collections.

1. Listed below are our payment plan options.

Balance	Minimum Payment Amount
Under$200	$40 per month
$201-$400	$80 per month
$401-$600	$120 per month
$601-$800	$160 per month
$801-$1000	$200 per month
$1001 and above	$250 per month

2. My current patient account balance is$_____as of (date) _____

Are claims still pending with insurance? (Circle) Yes No

I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount based on this plan as well. Patient's (or Guarantor's) Initials_____

3. The monthly payment will be$_____and payment will be due on the _____ of each month.

4. I hereby authorize Dream Riders to deduct the payment amount monthly on the day indicated above

5. Any questions or concerns that I may have had concerning this agreement were answered or discussed with the therapist.

Patient's (or Guarantor's) Initials _____

Patient Demographics

Name of patient:_____ D.O.B. ---------- M or F

Name of Parent or Guardian----------Patient's Height and weight----------

- Any Doctor diagnosis?----------
- How did you hear about our program?----------
- Do you have a doctor you would like evaluations, progress notes, etc. to be sent to? If so, please include his/her name:----------

Parent/Family Concerns

I. What are the primary concerns with your child's development? What are your goals for therapy?_____

2. What areas of development are causing concern? **Please circle the names of those areas of concern.**

Developmental Area	Developmental Area
Ability to calm themselves	Play
Activities of Daily Living	Positioning
Attention	Sensory integration/regulation
Behavior	Sleeping
Eating/Feeding	Social Interaction
Hand use	Speech/Language
Hearing	Temper tantrums
Mobility	Transfers
Motivation	Vision
Motor Control/Planning	Weight/Growth

Pregnancy/Delivery

3. Pregnancy proceeded (circle one): Normal / Complications
4. Length of pregnancy (number of weeks):_____
5. Delivery proceeded (circle one): Normal / Complications
6. Delivery was (circle one): Vaginal, C-section, emergency C-section
7. Child's length of hospital stay after birth (days/weeks/months):_____
8. Were there any of the following pregnancy complications? _____
9. Were there any of the following delivery complications? **Please check yes/no**

Delivery complication	Yes	No
Abruption placenta		
Breech presentation		
Low birth weight		
Negative vacuum		
on-progressive unproductive labor		
Occiput posterior position		
Placenta previa		

Delivery complication	Yes	10
Premature rupture of membranes		
Prolapsed cord		
Use of forceps		
Substance exposure		
Umbilical cord around neck		
Uterine rupture		
Other: Please Specify		

Birth information

10. Mother age at time of birth : _____
11. Birth hospital:_____
12. Needed to be transferred to another hospital (yes/no; if so what hospital):_____
13. Birth weight/height:_____ _____
14. Please add any other comment regarding pregnancy or birth: _____

Following birth

15. Did any of the following complications occur following birth? **Please check yes/no**

Postnatal complication	Yes	0
Anemia of prematurity		
Bronchopulmonary dysplasia (BP D)		
Cleft li p		
Cleft palate		
Club foot		
Cytomegalovirus		
ECMO		
Failure to thrive		
Hyperbilirubinemia		
Intrauterin growth retardation (IUGR)		
IVI-1 Bleed (if so, what grade?)		
Jaundice		
Meconium aspiration		

Postnatal complication	Yes	0
Necrotizing enterocolitis (NEC)		
Neonatal hypoxia		
Oxygen deprivation		
PD A		
Positive dependency		
Respiratory distress syndrome		
Respiratory stridor		
Respiratory syncytial virus (RSV)		
Retinopathy of prematurity (ROP)		
Thrombocytopenia (Low platelet count)		
Ventilator dependency		
VP Shunt		
Other complications		

16. Has your child been diagnosed with any specific diagnosis or syndrome(s)? Or are there any suspected diagnosis or syndrome(s)?

_____

_____

Medications/Allergies

17. What medication(s) is your child currently taking? _____

18. What vitamins, herbs, minerals, etc. is your child currently taking? _____

19. Does your child have any known allergies? _____

20. What was the date of the latest hearing test? What were the results? _____

21. What was the date of the latest vision test? What were the results? _____

Tests/Procedures

22. List all physicians, their specialty, and date of last visit your child secs:

Physicians	Special ty	Reason of Vis it	Date of Last Visit

23. List all surgeries/procedures and date your child has received:

Surgery **Date of Surgery**

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

24. List all diagnostic tests, dates, and results your child has received: (i.e., EEGs, swallow study, etc.)

Test	Date performed	Detailed results
1.)		
2.)		
3.)		
4.)		

Medical concerns

25. Has your child/does your child have any of the following medical concerns? Please check yes/no

Medica l concern	Yes	No
Allergies		
Arteriovenous malformation **(AVM)**		
Anoxic brain injury		
Asthma/respiratory problems		
Autism		
Baclofen pump		
Cerebral palsy		
Cerebral vascular accident (CVA)		
Chronic ear infections		

Medical concern	y es	No
Muscular dystrophy		
Osteoporosis		
Periventricular leukomalacia		
Reflux		
Scoliosis (degrees?)		
Seizure condition		
Sleep disorder/problems		
Shunt		
Torticollis		

Colic		
Constipation		
Diarrhea		
Down Syndrome		
Hydrocele		
Hip subluxation (degrees?)		
Laryngomalacia		

Traumatic brain injury (TBI)		
Tube feeding		
Tube in ears		
Vagal nerve stimulator		
Orthopedic conditions: (Specify)		
Neurological conditions: (Spec if y)		
Other:		

26. **If child has a seizure condition what do they look like? What is their specific seizure protocol?**_____

_____

_____

_____

Motor/Play Development

27. When did child begin to (what age? Or specify if are not yet performing task):
    a. Rolling over?
    b. Sitting alone without support?
    c. Began to crawl?
    d. Standing unsupported?
    e. Walking unaided.
    f. Fully toilet trained?
    g. Self-bathing?
    h. Dressing Self?
28. Is your child left or right handed ?
29. Are there concern with handwriting?
30. How does the child primarily get around the home?
31. What are the child's favorite toys and play activities?

Sensory Processing/Regulation

32. Does your child have any of the following behaviors/characteristics? **Check yes/no**

Behavior/Character is tic	**Yes**	**No**
Avoids getting messy		
Seeks out (craves) touch or movement		
Stumbles or falls frequently		
Appears awkward or less coordinated		
Flaps hands		
Bangs on surface, bands/hits head		
Fatigues quickly		
Has self-abusive behaviors		
Resists certain tasks or environments		
Spins things or self		
Is sensitive to lights, sounds or noise		
Resists touch		

Behavior/Characteristic	**Yes**	**No**
Walks on toes		
Lines up toys or objects		
Seeks out visually stimulating objects		
Seeks out stimulating sounds		
Resists certain movements		
Has figuring out how to move body or takes more time with movements.		
Does not tolerate certain textures		
Uses a lot of pressure when touching someone or holding object		
Has difficulty with transitions		
Has poor sense of body in space, runs into things		
Seeks support for posture		
Hyper focused		

33. .Social/Emotional Skills. Please check yes or no:

Behavior /Characteristic	Yes	No
Is easily distracted		
Calms self easily		
Gets angry/frustrated easily		
Is aggressive towards others		
Has poor eye contact		

Behavior/Characteristics	Yes	No
Prone to emotional outbursts		
Doesn' t allow others to join in play		
Prefers to play alone		
Has difficulties with separation from parent		
Difficulty following directions		

Speech and Feeding:

34. What is your child's primary way of communication (circle one)? Verbal / Non-verbal

35. Does your child use an augmented communication device (circle one)? Yes / No

36. .Describe any feeding current or past:_____

37. Food preferences:_____

38. Food dislikes:_____

39. What are feeding areas of difficulty? Please check yes/no

Area of Difficulty	Yes	No
Chewing		
Communicating needs		
Transitioning between foods		
Jaw shifts /slides/juts		
Drooling		
Swallowing		
Understanding words		

40. Are there any current feeding adaptations (Thickened liquids, adapted utensils, adapted seating, calories supplements, tube feeding, etc.)? If so, please describe specifics._____

_____

_____

41.Communication skills; please specify yes/no to the following questions:

Do es the child have:	**Yes**	NO
Speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is c alle d?		
Stutter?		
Recognize objects, people, and places?		

42.When did the child begin (at what age)?

a. Babbling?
b. Saying first words?
c. Naming familiar objects?
d. Putting 2 words together?
e. Using short sentences?

43.What was his/her first word(s)? _____

44. If the child is non-verbal select the primary method s of communication:

T pe of non- verbal communication	Yes	NO
Facial expressions Body language		
Manual sign language G		
Pointing		
Eye gaze		

45. Are there any other communication concerns at this time?

_____

_____

Home

46. Who does the child live with (e.g. mother, father, step-parents, siblings grandparents, etc.)?

IF siblings age please

_____

_____

47. How many stairs to get into the home? _____

48. Do you currently perform a home program with the child (stretching, strengthening activities brushing etc.)?

If so, please describe.

_____
_____
_____
_____
_____

49. Is the child involved in any community groups or sports activities? If so, please describe.:

_____
_____
_____
_____

Therapy / School History

49. What grade in school is your child?

55. Where do they go to school?

56. Does your child have an I F P (0-3) or IEP (school)?

57. Has your child had a psychological or neuropsychological evaluation completed?

58. Please fill out the following regarding therapy services your child is receiving:
Service refers to the discipline received.
Status refer to ongoing or di charged (received in the past).
Frequency refers to how often these services were received (I x/week, 2x/month etc.).
Location refers to where services were received (home school, outpatient, etc.).

Serv ice	Status	Frequency	Location
Audiology			
Behavior therapy			
EI services			
Vision therapy			
Nutrition			
Occupational therapy			
Physical therapy			
Social work			
Speech/ language therapy			
Developmental follow-up clinic			
Other			

Consent for Release of Information

I hereby authorize: ----------

To release information from the records of: ---------- DOB:----------
(Participant's name)

The information is to be released to:_____

For the purpose of developing an individualized Occupational Therapy program, the information to be released is marked below

Medical History
Physical Therapy evaluation, assessment and program plan
Occupational Therapy evaluation, assessment and program plan
Speech Therapy evaluation, assessment and program plan
Classroom Individual Education Plan (I.E.P)
Psychosocial evaluation, assessment and program plan
Cognitive-Behavioral Management plan

other

Consent Signature:_____ Date: _____
(parent/guardian/
participant)

Print Name_____

parent/guardian/
participant)

Media Release

Our Occupational Therapy participants, families, and volunteers are our best advocates I We occasionally have the opportunity to feature one of our participants in the media, including printed material, television, newspaper, radio or the internet, to promote programs and services

Please CIRCLE your media consent or non-consent below

I DO CONSENT

I DO NOT CONSENT

Consent to and authorize the use and reproduction by Jennifer Davis of any and all photographs and any other audio/visual material taken of me or my child for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature:_____ Date:_____

(Client, Parent or Legal Guardian)

Where function and movement meet to make Amazing Achievements.

Jennifer Davis, OTR/L,HPCS

Amazing Achievements OT, PLLC

Date:_____

Referral Form

Client Name:_____Date of Birth:_____

In order for us to further service the above client we need a referral from their primary care physician for the following services:

Occupational Therapy

With a frequency of:

1-2 X per week

Other

And the referral must also include the following for insurance purposes:

- Date
- Diagnosis
- Doctor's signature

For your convenience, you may email the referral with a HIPPA confidentiality notice included to our facility at: jenniferhpot@gmail.com

Thank You,

Jennifer Davis,OTR/L, HPCS

Where function and movement meet to make Amazing Achievements.

Jennifer Davis, OTR/L,HPCS

Amazing Achievements OT, PLLC

Date:_____

Referral Form

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