The Children's Therapy Center

Dear New Patient and Family:

Thank you for scheduling an appointment for your child at our office. We are greatly looking forward to meeting you. Enclosed are 7 forms for you. Please return the starred forms PRIOR to your appointment.

**Patient Information Sheet – please complete all areas.
**Medical History Form – please complete all areas appropriate to your child. This is a 2-page form.
**Patient Consent and Authorization Form – please sign all areas.
**Consent to Communicate Health Care Information – please initial those you prefer and sign.
**Release and Consent for Photo/Videography – please sign if you agree.
.

** Return these forms ahead of time by emailing or faxing to the information below:

Office	Phone	Fax	Email
Springfield	703-569-7500	703-866-0158	springfieldfrontdesk@pediatric-therapy.com
Sterling	703-707-9060	703-707-9022	sterlingfrontdesk@pediatric-therapy.com
Gainesville	703-291-1254	571-248-0304	gainesvillefrontdesk@pediatric-therapy.com
Falls Church	571-378-1272	571-378-1275	fallschurchfrontdesk@pediatric-therapy.com

Family Guide to The Children's Therapy Center– this is general information about our office for you to read and keep at home.
HIPAA Privacy Notice – for your review and files.

Please arrive for your first appointment at least 15 minutes early to complete the paperwork process. Remember to also bring your insurance cards, identification and a prescription from your doctor for the therapy that your child is receiving.

While you wait for your visit to come, please check out our website at http://www.pediatric-therapy.com/ to learn more about us. The website can also provide you with directions to the office.

Thank you again and we are anticipating your visit. Have a terrific day!

Enthusiastically,

The Staff at The Children's Therapy Center

Today's Date:_____

Patient Information Sheet

***** PLEASE COMPLETE ALL INFORMATION *****

PATIENT DEMOGRAPHICS	
Patient's Name	**Date of Birth**
Address	**Soc Sec #**
Caregiver's Name	**Home Phone**
Employer	**Work Phone**
Cell Phone	**Soc Sec #**
Email Address	
Caregiver's Name	**Home Phone**
Employer	**Work Phone**
Cell Phone	**Soc Sec #**
Email Address	

MEDICAL INFORMATION
Diagnosis
Reason for Coming Today
Primary Physician Information **(who is responsible for primary healthcare of child)**
Physician Name **Practice Name**
Address **Office Phone**
Secondary Physician **(any other physician reports should be sent to)**
Physician Name **Practice Name**
Address **Office Phone**

BILLING INFORMATION	
Person Responsible for Bills **(who is responsible for all unpaid balances, copays, and deductibles)**	
Name	**Phone**
Address	**Soc Sec #**
Insurance Information **(copy all information from your card and give the card to the front desk for copy)**	
Primary Insurance Name	**Policy ID #**
Address	**Group #**
	Phone #
Cardholder's Name	
Relationship to Patient	**Birthdate**
Secondary Insurance	**Policy ID #**
Address	**Group #**
	Phone #
Cardholder's Name	
Relationship to Patient	**Birthdate**

How did you hear about us?	
Referring person/contact	
Address	**Phone**

Medical History Form

Child's Name:	Date of Birth:
Name of Person Completing Form:	Relationship:

PRESENT MEDICAL INFORMATION

Please complete this section completely

Current Diagnosis:				
Who Referred You to Therapy?				
Present Therapy Concerns:				
Other Medical Concerns/Precautions:				
General Health of Your Child:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Has your child previously received or currently receiving behavioral services?			☐ yes	☐ no * If yes, please complete Behavior Questionnaire on Website
What is the name of the agency or behavior support professional working with your child?				
Does your child have a current Positive Behavior Support Plan or a Behavior Intervention Plan?			☐ yes	☐ no
If yes, when was this implemented and by whom?				
Present Medications:				
Does your child have a history of any seizures?			☐ yes	☐ no
If yes, please explain.				
Has your child ever had any previous therapies?			☐ yes	☐ no
If yes, please explain when, where, and what type.				
Has your child had formal vision testing?			☐ yes	☐ no
If yes, where and what were the results?				
Does your child wear glasses?			☐ yes	☐ no
Is your child presently followed for vision care?			☐ yes	☐ no
Has your child had formal hearing testing?			☐ yes	☐ no
If yes, where and what were the results?				
Does your child have any adaptive/medical equipment?			☐ yes	☐ no
If yes, please explain.				
Does your child follow any special diet?			☐ yes	☐ no
If yes, please explain.				
Does your child have any allergies?			☐ yes	☐ no
If yes, please explain.				

PRESENT ABILITIES/STRENGTHS

Please complete this section completely

Describe the following about your child:
Ability to communicate wants/needs:
Attention span:
Ability to follow directions:
How does your child handle stress? Please describe their coping skills.
Ability to be redirected:
Strength and Balance:
Hand dominance/preference:
Writing skills:
Visual skills:

INJURY/SURGERY INFORMATION

Please complete this section if therapy is related to an injury or surgical procedure

Date of Injury:

Please explain the injury and how it occurred?

Was surgery performed due to this injury? ☐ no ☐ yes Date of surgery:_____

Where was surgery performed?

Length of hospital stay?

Please explain the details of the surgery.

Did you have any therapy concerns for your child prior to this event? ☐ yes ☐ no

If yes, please explain.

Does your child have any medical or movement precautions because of this? ☐ yes ☐ no

If yes, please explain.

Has your child received previous therapy for this injury/surgery? ☐ yes ☐ no

If yes, please explain

BIRTH HISTORY

Please skip this section if your child is not here for a birth or developmental problem

Was pregnancy full term? ☐ yes ☐ no **Gestational Weeks Completed:**_____weeks

Type of Delivery: (check all that apply)**:** ☐ vaginal ☐ caesarian ☐ breech ☐ forceps ☐ suction

Length of Hospital Stay:

Was the baby at any time in distress? ☐ yes ☐ no

Birthweight: _____pounds _____ounces

Please explain any complications the mother and/or baby had before, during, or after the birth:

Was there any type of diagnosis or medical concern about the baby after birth?

Please describe any family history of developmental or learning problems:

DEVELOPMENTAL HISTORY

Please skip this section if your child is not here for a birth or developmental problem

At what approximate age did your child reach the following developmental milestones (if applicable)?

_____roll over	_____say first word	_____feed self
_____sit alone	_____use 2 word sentences	_____dress self
_____creep on all fours	_____speak clearly	_____use crayons
_____walk independently	_____drink from a cup	_____cut with scissors

Has your child been evaluated by a Developmental Pediatrician? ☐ yes ☐ no

If yes, who and where?

Does your child have a current IFSP/IEP? ☐ yes ☐ no

If yes, please bring provide us with a copy.

THERAPY GOALS

Please describe what your goals for therapy are. What do you hope therapy will accomplish?

Patient Consent and Authorization Form

Patient Name:
Consent to Treatment and Authorization for Release of Information
I hereby authorize The Children's Therapy Center and its staff to evaluate and treat the above-named patient as prescribed by my physician and recommended by the therapist. I understand that I have the right to remain present during all therapy sessions and ask any questions I may have of the therapy program. I authorize The Children's Therapy Center to request appropriate information from my child's physicians. I further authorize The Children's Therapy Center to release any pertinent information to these physicians. I have read and understand the above consent.
Parent/Guardian Signature: Date:

Telehealth Patient Consent and Authorization Form

Patient Name:
Telehealth Consent to Treatment and Authorization for Release of Information
I hereby authorize The Children's Therapy Center and its staff to provide the above-named patient therapy as prescribed by my physician and recommended by the therapist, through the method of telehealth/telemedicine. I understand that I am obligated to remain present during all sessions, and ask any questions I may have of the therapy program. I authorize The Children's Therapy Center to request appropriate information from my child's physicians. I further authorize The Children's Therapy Center to release any pertinent information to these physicians. I authorize payment directly to The Children's Therapy Center and its employees for telehealth services provided to my child. This is a direct assignment of my rights and benefits under my insurance policy. I hereby give permission for my child to be on video and potentially recorded during the telehealth sessions.
Parent/Guardian Signature: Date:

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)
I hereby acknowledge that I can print off a copy of The Children's Therapy Center's Privacy Practices from the website. In addition, I hereby consent to the use and disclosure of mine and my child's personal health information for the purposes of treatment, payment, and health care operations.
Parent/Guardian Signature: Date:

Assignment of Benefits
I hereby authorize payment directly to The Children's Therapy Center, Inc. and its employees for therapy services provided to my child. This is a direct assignment of my rights and benefits under my insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original.
Parent/Guardian Signature: Date:

Consent to Communicate Health Care Information

Patient Name:

Due to The Children's Therapy Center specialty type of practice, there may be times when it is necessary to leave personal, insurance, appointment, and therapy related information with someone other than a child's parent/guardian, or on an answering machine. We also communicate through email. Under the new HIPAA guidelines, we are no longer permitted to leave such messages, without your prior approval.

Please review each of the following, signing your initials at each space you approve, and then sign the bottom of this form.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding insurance/billing matters with anyone who answers my home phone.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding insurance/billing matters on my home or cell phone voicemail.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding insurance/billing matters at my place of employment, using the telephone number provided by me.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding appointments with anyone who answers my home phone.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding appointments on my home or cell phone voicemail.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding appointments at my place of employment, using the telephone number provided.

_____ I authorize the staff of The Children's Therapy Center to email and text messages regarding appointments using the email address and telephone number provided by me

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding therapy matters with anyone who answers my home phone.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding therapy matters on my home or cell phone voicemail.

_____ I authorize the staff of The Children's Therapy Center to leave messages regarding therapy matters at my place of employment, using the telephone number provided by me.

Cell Phone Number: _____

Email Address: _____

Parent/Guardian Name:_____ Relationship:_____

Parent/Guardian Signature:_____ Date:_____

WELCOME TO THE CHILDREN'S THERAPY CENTER. Thank you for the opportunity to work with you and your child. All of us here are greatly looking forward to watching your child develop to their fullest potential and will do our very best to facilitate that growth. We have developed the following guidelines to help welcome you to our center and make your therapy experience as enjoyable and easy as possible.

Springfield Center
8348 Traford Ln
Suite 200
Springfield, VA 22152

Center Manager: Darcie Scheffler OTR/L
Front Desk Coordinator: Rosemarie Wilson
(703) 569-7500, Fax (703) 866-0158

Sterling Center
100 Carpenter Dr
Suite 140
Sterling, VA 20164

Center Manager: Kathryn Sawruk OTR/L
Front Desk Assistant: Gina Nous
(703) 707-9060, Fax (703) 707-9022

Gainesville Center
7001 Heritage Village Plaza
Suite 175
Gainesville, VA 20155

Center Manager: Ashley Marsh PT, DPT
Front Desk Coordinator: Tameka Martinez
(703) 291-1254, Fax (571) 248-0304

Falls Church Center
803 West Broad Street
Falls Church, VA 22046

Center Manager: Leah Kania PT, DPT
Front Desk Coordinator: Elaine Patterson
(571) 378-1272, Fax (571) 378-1275

Corporate Administration

Samantha Gorrell, PT, DPT, VP Outpatient Operations, (215)259-2767, sgorrell@theraplayinc.com
Kelly Moskal, PT, MPT Associate Director of Outpatient Services, (703) 707-9060, kmoskal@pediatric-therapy.com
Elana Graves, Director of Front Desk Operations, (484) 370-2170, egraves@theraplayinc.com
Jayne Dunn, AR Specialist, (484) 787-2237, jdunn@theraplayinc.com

Center Addresses and Phone Numbers can be found on our website

pediatric-therapy.com

Part of the THERAPLAY Family of Companies

BILLING GUIDELINES

1. It is our goal to provide our patients with the best and affordable therapy services possible. We will verify your insurance benefits specific to therapy and will explain these benefits to you. **We recommend that you also verify your benefits – the information we receive from your insurance may be incorrect, and you are ultimately responsible for all charges.**
2. We request that all copays, coinsurance, deductibles, and any other fees that are not covered by your insurance be paid at the time of service. We also require the social security numbers (last four digits) of the patient and the subscriber at the time of the first visit, or we will not be able to provide services.
3. If privately paying for therapy, we require that you pay for sessions in full at the time of therapy.
4. We offer a variety of therapy products that may be recommended to you for purchase to facilitate your child's therapy program. You must pay for any item prior to receiving it. We are sorry but we cannot bill you or your insurance for any therapy products.
5. For your convenience, we accept cash, checks, VISA, MasterCard and Discover. We also have a payment portal through our website.

TREATMENT GUIDELINES

1. We do not permit eating or drinking in our waiting room. We have children who have serious allergies and we greatly appreciate your cooperation. Baby bottles, nursing, water, and coffee are allowed.
2. Parents are welcome and encouraged to remain present during all therapy sessions. However, if you leave during the session, please be sure to return 15 minutes prior to the end of the session so that the therapist may review the session and instruct you in new home activities. Do not arrive back to a session after therapy has ended; our staff has other scheduled children to treat. We cannot take responsibility to watch your child outside of therapy time.
3. Family members are encouraged to participate in therapy sessions to make them active facilitators in their child's program. Home programs are implemented with family members to ensure the program's success in each unique family environment. To fully be able to learn and participate, consider leaving siblings at home. When this is not possible, we will do our best to provide family centered care without taking away from your child's therapy, or others' therapy within the therapy environment.
4. The Children's Therapy Center believes in a team approach. Your child will be treated by a number of different staff members, including therapists, assistants, and students, and may interact with aides, residents and volunteers. The team approach achieves greater progress with goals, and better carryover into natural environments. Therapy schedules/assignments may change without notice, in the event of something unforeseen occurring; however, the majority of your appointments will be with exactly who you schedule with.
5. Please be sure to let a therapist know if your child experiences any discomfort or becomes unnecessarily upset due to therapy. Although some procedures may need to be uncomfortable, it is our goal to provide your child with the most enjoyable and fun experience as possible.

SCHEDULING GUIDELINES

1. All therapy is by appointment only.
2. When scheduling appointments, you may schedule up to one month (4 weeks) of appointments at a time, within your insurance authorization. No appointments will be scheduled outside of your insurance authorization at any time. We know this may cause inconvenient appointments at times; however, this policy is strictly enforced. There is never a guarantee that your insurance will continue to authorize future visits.
3. We strongly suggest families become active participants in the insurance process and contact their insurance company directly regarding pending authorizations. It has been our experience that the insurance companies are far more efficient when a family member becomes involved.
4. We require 24 hours' notice for cancellation. For each appointment, a full hour of staff time and treatment space are reserved for your child, therefore proper notice allows us adequate time to potentially fill that time slot with another patient. Please call to cancel any appointment – we do not accept emails to our website to cancel an appointment. Patient reminder emails will be made each day for the next day's appointments to assist families with keeping their scheduled appointments.

5. There is a $35.00 charge for all appointments that are not cancelled with sufficient notice, and for all no-show appointments, and this fee increases with each subsequent no-show or late cancel. This fee will be waived if the cancelled appointment is rescheduled into an available appointment slot within the next 7 days.
6. If you are late for an appointment, your therapy time will be cut short accordingly, and end at the scheduled time. You will be charged up to the full amount for the session.
7. Your physician has prescribed therapy for your child as an important tool in your child's development. It is your responsibility to ensure to the best of your ability that your child receives therapy at the recommended frequency by keeping all scheduled appointments and making up all missed/cancelled visits. Failure to do so will disrupt your child's progress and may interfere with your insurance authorization.
8. If permitted by your insurance, we highly recommend at times double booking appointments if your child receives multiple therapies. When a child is being treated by two or more therapies, it greatly helps the therapists to co-treat with another therapy so that goals can be carried over between all therapies. This is not something that needs to be done all of the time, but randomly throughout therapy is extremely beneficial to your child.

INCLEMENT WEATHER GUIDELINES

In the event that The Children's Therapy Center is closing due to inclement weather, a message will be placed on the voicemail system, our website and our Facebook page. For a full day of closing, or for a late opening, the message will be on the voicemail, website and Facebook page by 6:00am. We will not be calling to cancel appointments. Please call and check to see if your appointment is still on. For early closings during the day, we will be calling families. Our staff will call each missed appointment the next business day to reschedule all missed appointments.

BEHAVIORAL GUIDELINES

Our role is to increase your child's skills through physical, occupational and speech therapy. While our therapists are provided training in managing behavior and safety techniques, the intention of each therapy session is to progress toward meeting the goals within the respective discipline of service. We do not have a behavioral therapist on staff in our outpatient centers, and therefore do not provide behavioral therapy within your child's session. If your child demonstrates extreme behaviors, such as aggression towards self or others and these behaviors negatively influence progress toward goals, a support person may be required to attend all therapy sessions. In addition, your child may be requested to leave The Children's Therapy Center if we feel we cannot meet your child's needs or if the behaviors demonstrated pose too great of a risk to themselves and others. It is of the utmost importance that we maintain a safe, therapeutic environment for your child, our staff, and others at all times. If you are in need of behavioral services, we will provide you available resources.

SOCIAL MEDIA GUIDELINES

We ask that families and caregivers respect our staff members' privacy when using social media. At The Children's Therapy Center, we strive to maintain your child's and family's confidentiality at all times, including social media. We encourage you to "like" The Children's Therapy Center's Facebook page to keep up to date on events rather than connecting with staff through personal social media sites. Our staff are prohibited from "friending" any current patients and their families.

UNDER THE INFLUENCE/IMPAIRMENT

The Children's Therapy Center respectfully requests that family members, caregivers, and those providing care and/or support to patients of The Children's Therapy Center shall not attend a patient visit while under the influence and/or impaired by drugs and/or alcohol. In creating a safe environment for the patient and maintaining responsibility for the safety of the child, we will need to take action in the best interest of the child in the event it is determined the family member or caregiver is impaired due to drugs and/or alcohol.

CONTRABAND

The Children's Therapy Center. respectfully requests that clients, family members, caregivers, and so forth not bring contraband into our outpatient centers – even in communities where carry is permitted by law. Contraband is defined as alcoholic beverages, controlled drug substances, unauthorized drugs, firearms, lethal weapons, cameras and sound-recording devices. Bringing contraband into the outpatient environment

violates the environment in which the Company endeavors to create – a safe place for therapeutic exercise.

ILLNESS AND INFECTION GUIDELINES

1. Please call our office as soon as you suspect that your child is sick. This is for the safety of your child, our staff, and other children at the office.
2. We request that you keep your child home if any of the following circumstances occur:
    a. Vomit two or more times in the last 24 hours
    b. Fever of above 101 degrees in the last 24 hours
    c. Unexplained body rash, hives or bumps on skin
    d. Head lice, scabies or other infestation until 24 hours after treatment
    e. Diagnosed infectious condition such as conjunctivitis, chicken pox, coxsackie, staph/MRSA, and whooping cough.

Theraplay Family of Companies Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you:

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. In some limited circumstances, we may say "no" to your request, and you can ask that the denial be reviewed.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information: You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make), except if required by regulation. We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the information found on our website. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions if feasible or required by law.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, share information in a disaster relief situation, include your information in a facility directory. If you are not able to tell us your preference, for example if you are unconscious or unavailable, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. We may share certain information after you have died.

In these cases, unless allowed by applicable law, we *never* share your information unless you give us written permission: Marketing purposes (except as described below), sale of your information, most sharing of psychotherapy notes.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you: We can use your health information and share it, electronically or otherwise, with other professionals who are treating you. We can give out your information for other treatment purposes, such as leaving an appointment reminder message. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization and engage in other health care operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can also share for other health care operations purposes permitted by law or regulations. Example: We use health information about you to manage your treatment and services. We may share health information with other entities for their health care operations and other lawful purposes.

Bill for services: We can use and share your health information to bill and get payment from health plans, from you, or from other entities, or to help other entities get payment. Example: We give information about you to your health insurance plan so it will pay for your services. We may give information to entities that help us collect payments. We may share your information with other entities for their payment purposes.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as: preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations and tissue banks.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond and participate in lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena. We can also share information when a protective order is in place.

Other Uses and Disclosures

Business Associates: There are some health-related services provided through contracts with third parties, called "business associates," that may need the information to perform certain services on our behalf. Examples include software or technology vendors we may utilize to provide technical support, attorneys providing legal services to us, accountants, consultants, billing and collection companies, and others. When such a service is contracted, we may share your protected health information with such business associates and may allow our business associates to create, receive, maintain or transmit your information on our behalf in order for the business associate to provide services to us, or for the proper management and administration of the business associate. Business associates must protect any health information they receive from, or create and maintain on our behalf. In addition, business associates may re-disclose your health information for their own proper management and administration, to fulfill their legal responsibilities, and to business associates that are subcontractors in order for the subcontractors to provide services to the business associate. The subcontractors will be subject to the same restrictions and conditions that apply to the business associate. Whenever such an arrangement involves the use or disclosure of your information to our business associate, we will have a written contract with our business associate that contains terms designed to protect the privacy of your information.

De-identified information: We may use or disclose your health information to create de-identified information or limited data sets, and may use and disclose such information as permitted by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official as permitted by applicable laws and rules.

Marketing: We may use and disclose your protected health information to communicate face-to-face with you to encourage you to purchase or use a product or service, or to provide a promotional gift of nominal value to you. We may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be useful to you.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. While we take privacy and security very seriously, sometimes things go wrong. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Other State and Federal Laws

We may ask you for consent to share certain medical information. This consent is required by Pennsylvania law for some disclosures and allows us to be certain that we can share your medical information for all of the reasons explained in this notice. We may also ask for your consent to share certain sensitive information that may have extra protection under state or federal laws.

This Notice of Privacy Practices applies to The Theraplay Family of Companies, Effective date: January 1, 2017

The Children's Therapy Center

RELEASE AND CONSENT FOR PHOTO/VIDEOGRAPHY

PRINTED NAME OF CHILD: _____

PRINTED NAME OF PARENT/GUARDIAN: _____

RELATIONSHIP TO CHILD: _____

PLEASE INITIAL EACH OF THE BELOW TO SIGNIFY YOUR AGREEMENT:

_____ I hereby give The Children's Therapy Center, the right and permission, with respect to the photographs
Initials and videos taken of my child, in which I may be included, and with respect to statements taken and recorded:

a) to use, re-use, publish the same in whole or in part, individually or in conjunction with the other photographs and/or videos, or written material, for purposes including, but not by way of limitation, illustration, promotion, and advertising and trade, and;
b) to use my name and my child's in conjunction therewith if they so choose.

I also hereby release and discharge The Children's Therapy Center and its employees and agents from any and all claims and demands arising out of or in connection with the use of the photographs, videos, and/or recorded statements including any and all claims for libel or slander.

_____ I authorize the use of photographs or videos taken of my child to be used for the therapeutic care of my
Initials child.

_____ I agree to use any photographs or videos taken of my child by myself or any caregiver, during therapy
Initials sessions, solely for the purpose of celebrating the personal accomplishments and milestones of my child. Prior to taking a photograph or video, I will ensure no other child or parent is in the background for any portion of the photograph or video.

I am the parent/guardian of the child photographed or videoed and have read the foregoing and fully understand the contents thereof.

_____ _____
Signature of Parent/Guardian Date

For Office Use Only

Office Location: _____ Date: _____

Staff Member(s) Also In Photo: _____

Staff Member Signatures: _____

Brief Description of Photo: _____

_____

_____