



Spot On Therapy Group, LLC Client Contact Information

Client Name: _____ Today's Date: _____
DOB: _____
Sex: _____
Address: _____ City: _____
State _____ Zip _____ Email Address: _____
Home Phone: _____ Cell Phone: _____

Referred by: (name and title) _____
Primary Care Physician _____
Name of Practice _____
Address _____ Phone _____

If client has a legal guardian, please complete the following:

Name: _____ Relationship to Client: _____
Address (if different from above) _____
Phone (if different from above): Home Phone _____ Cell _____
Work Phone: _____ Employer _____

____ By initialing here, you authorize Spot On Therapy Group to contact you via the email address provided above, regarding appointments and to send relevant medical information, including reports.

In case of emergency contact:

Name _____ Phone _____
Relationship to client _____

Insurance/Payment Information

Person responsible for payment of services: _____
Insurance Company _____
Primary Insured's Name _____ DOB _____
Insured's ID Number _____ Insured's Group Number _____
Relationship to client _____ Primary Insured's Social Security # _____

Do you have a secondary insurance/Medicaid?

Insurance Company _____ Policy/ID# _____

If my insurance policy/plan limits the number of therapy visits allowed, I understand that I am responsible for keeping track of the number of used or remaining visits. If the client is seen beyond the approved number of visits, I understand that I am responsible for all charges that exceed the allowed number of visits approved by my insurance company.

Initials _____ Date _____



RELEASE OF INFORMATION AGREEMENT

Client Full Name _____ Date of Birth _____

I request and authorize Spot On Therapy Group, LLC to release/exchange healthcare information of the client listed above to:

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)

This authorization expires on _____

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)

This authorization expires on _____

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)

This authorization expires on _____

.....

Client/Legal Guardian Printed Name

Client/Legal Guardian Signature

Date

ATTENDANCE, CANCELLATIONS, AND DISCHARGE POLICIES (Rev 9/1/24)

Regular and consistent attendance is required in order to show treatment progress and to maintain your scheduled appointment time.

Cancellations must be made with at least 24 hours' notice, or a \$50.00 fee will be charged. This applies to clinic, telehealth, and community based appointments. We understand that due to illness or other unexpected events it may be necessary for you to occasionally cancel a therapy appointment. Please call your therapist or the office manager and leave a message if you reach voicemail. Make up sessions are encouraged.

MISSED OR NO SHOW APPOINTMENTS : A fee of \$50.00 will be charged if the 24-hour notice is not given; this fee is charged in an effort to deter unnecessary missed appointments. This fee cannot be billed to your insurance company and will be due and payable prior to your next scheduled treatment session. *Two no show/no call appointments **will** result in removal from the therapy schedule.*

TARDINESS: You have chosen a specific day/time for your therapy appointment. If you arrive late, the treating therapist will determine if there is enough time to proceed with the session, and the session will conclude at the regularly scheduled time. *We reserve the right to remove you/your child from the schedule if you do not consistently arrive at your scheduled appointment time.*

Being absent or tardy both impedes the therapy process and financially impacts our staff and Spot On Therapy Group. We also have a long waitlist of families who need therapy services. If you are faced with a scheduling challenge, please see the front desk in order to find a more preferable therapy time.

DISCHARGE POLICY It is the policy of Spot On Therapy Group to discharge clients who meet one of the following criteria: no longer demonstrates need for intervention, does not appear to benefit from continued services, is not meeting financial responsibilities to Spot On Therapy Group, does not meet the required attendance (as outlined above), is requested by the parent/caregiver, or at the discretion of the agency.

By signing below, I acknowledge that I have fully read and understand the Spot On Therapy Group Attendance, Cancellations, and Discharge Policy (updated 9.1.24), and I acknowledge that Spot On Therapy Group monitors attendance.

Client Full Name _____ Date _____

Parent/Guardian Printed Name (if applicable) _____

Initials By initialing, you give Spot On Therapy Group permission to send you text and/or email appointment reminders. Please indicate what phone number or email to use for reminders. _____

Client/Parent/Guardian Signature _____



Spot On Therapy Group
4840 Waller Rd. Suite 200
Richmond, Virginia 23230
NPI 1508249632 Phone: 804 893-5010

Telehealth Consent Form

Client's name: _____ DOB: _____

Legal Guardian's Name: _____

Check all that apply now or in the future.

Visit type(s): OT Speech PT Neurofeedback

Telemedicine involves the use of electronic communications to enable health care providers at a different location to engage in live two-way video conferencing for the purpose of providing speech/OT/PT services. I understand that electronic systems used during the Telemedicine session will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data (e.g. password protected screensavers, encrypted data files) and to ensure its integrity against intentional or unintentional corruption.

1. **Confidentiality:** I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent as outlined by HIPAA (Health Insurance Portability and Accountability Act).
2. **Patient Rights:** I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my therapy at any time, without affecting my right to future care or treatment. I will be informed of any other people who are present at either end of the telehealth encounter and have the right to exclude anyone from either location. All confidentiality protections required by law or regulation will apply to my care.
3. **Medical Records:** A contact note will be written during/after each telehealth appointment and will be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

I hold Spot On Therapy Group harmless for interruptions, unauthorized access, technical difficulties, and call termination during our telehealth video calls. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the video/audio connections are not adequate for my situation. It is my preference and/or need for my OT/ST/PT provider to deliver services via telehealth either for medical-health/safety reasons until we are able to meet face-to-face (if related to COVID-19) or parent preference if always covered by insurance.

I understand and consent to participate in Telehealth Services for Speech/OT/PT therapy.

Client/Legal Guardian Signature

Date



FINANCIAL POLICY AGREEMENT

Client Full Name: _____ Date: _____

If you have Health Insurance, we want you to receive your full benefit. Our office team can assist you in completing your insurance forms and verifying benefits/coverage. If Spot On Therapy Group is in network with your insurance provider, you are responsible for your deductible and the co-payment or coinsurance (the portion insurance does not cover) at the time services are provided. Please note, the portion of the total fees covered by your insurance may be different than the amount quoted on the day of service. You are encouraged to verify your insurance policy benefits. You are responsible for any outstanding balance after insurance has been applied.

By initialing, I understand that I am responsible for the payment of a one-time \$100.00 Educational Consultation fee for the initial evaluation. This fee cannot be submitted to insurance and is the client's responsibility. Initial _____

PAYMENT FOR SERVICES: Spot On Therapy Group accepts cash, checks, Visa, MasterCard, Discover, American Express and PayPal.

CONTRACTUAL AGREEMENT:

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

I understand all client co-payments are due payable at the time services are rendered. I authorize payment directly to Spot On Therapy Group for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the above named client and any insurance payments will be credited to the account. In the event the bank returns any check given in payment on this account, unpaid for any reason, a \$35.00 charge will be added to the account balance each time a check is returned. If all charges are not paid in full within sixty (60) days from the date of service, I agree to pay the service charge of eighteen percent (18%) per month with a twenty-one percent (21%) annual interest on the unpaid balance. If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to attorney's fees and all court costs.

By signing below, I acknowledge that I have fully read and understand the Spot On Therapy Group Financial Policy Agreement.

Legal Guardian Printed Name (if applicable) _____

Client/Legal Guardian Signature _____ Date _____



PRIVACY PRACTICES POLICY

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinicians or other treatment team members. *We may disclose PHI to any other consultant only with your specific written authorization.*

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support certain business activities including, but not limited to, sharing your PHI with third parties that perform various business activities (e.g., billing or typing services) only if we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Your PHI may be disclosed via email, if you have given written permission, for appointment reminders, and to provide information about treatment alternatives or other health-related benefits and services.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.



Spot On Therapy Group

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose information to family members that are directly involved in you or your child's treatment *with your verbal permission.*

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask for amendment of the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. ****Please notify Spot On Therapy Group, LLC if you would like a copy. Please also check the appropriate box on the signature page, indicating you received a copy of this notice.**



Spot On Therapy Group, LLC
Written Acknowledgement Form

By signing this form, I acknowledge and agree as follows:

I have been given the opportunity to read Spot On Therapy Group's Notice of Privacy Practices policy statement (previous 2 pages), prior to signing this acknowledgement form.

The Privacy Practices policy statement includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Spot On Therapy Group, LLC to treat me and/or my child and to obtain payment for that treatment.

_____ By initialing, I indicate that I **would** like a printed copy of Spot On Therapy Group's Notice of Privacy Practices Policy.

Name of Client

Date

Legal Guardian Printed Name (if applicable)

Signature of Client/Legal Guardian



Spot On Therapy Group
Adult Client Background Information

Date: _____

Full Name _____ Age: _____ DOB: _____

Preferred Name/Nickname: _____ Sex: _____

Occupation: _____

How did you find out about us? _____

What is your major concern that led you to seek help?

How long have you had these concerns? _____

What others concerns do you have?

Please check the areas of your life that are affected by these issues/concerns:

Home

School

Work

Church

Public Places (please specify) _____

Other _____

With whom do you currently live? _____

Please select how you communicate (select all that apply):

verbally

gestures

signs

high-tech AAC

low-tech AAC/picture boards



Please check any of the following medical professionals from whom you are currently receiving or have received services, and include any formal diagnoses/recommendations given.

<u>Area of Service</u>	<u>Clinician</u>	<u>Date</u>	<u>Diagnosis/Recommendations</u>
Occupational Therapists	_____	_____	_____
Physical Therapist	_____	_____	_____
Speech Language Pathologist	_____	_____	_____
Vision Specialist	_____	_____	_____
Hearing Specialist	_____	_____	_____
Neurologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychologist	_____	_____	_____
Counselor	_____	_____	_____
Other:	_____	_____	_____

Are you allergic to any medications? No

Yes

If yes, list allergy and reaction:

Are you allergic to anything other than medications? No

Yes

If yes, list allergy and reaction:

- List any medications you are currently taking in the columns below. (Use back of sheet if needed)

Medication

Purpose

What medical or physical problems do you currently have or have previously had? Mark an *X* and then describe below.

	Past	Present	If yes, please explain
Cardiac Problems			
Ear infections, frequent colds			
Poisoning, drug use or overdose			
Hospitalizations or surgeries			
Vision/hearing difficulties			
Balance/Coordination Issues			

	Past	Present	If yes, please explain
Muscle or Verbal Tics			
Speech disorders			
Serious accidents/Injuries - including concussions and loss of consciousness			
Very sensitive to feel of labels, seams, textures in clothes or food taste, smell, or texture			
Bothered by loud or unexpected noises			
Picky eater			
Shortness of breath			
Headaches			
Dizziness			
Motion Sickness			
Unusual Fears/Worries			
Depression			
Anxiety			
Substance Abuse			
History of Trauma			
Sleep Problems			
Social Problems			
Attention or learning problems			
Significant stressors			

Other:



Are you currently in school? No If yes, which school do you attend and what are you studying?

Please include anything else you think might be helpful for us to know about.
