

Achievement Therapy Services, Inc.

32531 N. Scottsdale Rd. Ste 105-162

Scottsdale AZ 85266

(480) 488-3946 office

(480) 488-3956 fax

Dear Parent/Caregiver,

Welcome to Achievement Therapy Services, Inc.! We are excited to be able to assist you and your child in his or her development. We pride ourselves on quality service provision, and are committed to doing what we can to serve your family best.

The enclosed packet is important information, which is needed before we can proceed with your child's therapy. Please complete these forms and return them to our office as soon as possible, as we cannot begin services for your child until they are received. If you have any questions, please feel free to contact our office at the above number.

Again, we look forward to providing the best services possible for your child and family. Let us know how we can help!

Sincerely,

Achievement Therapy Services, Inc.

ACHIEVEMENT THERAPY SERVICES
32531 N SCOTTSDALE RD
SUITE 105-162
SCOTTSDALE AZ 85262
OFFICE 480 488 3946
FAX 480 488 3956

INSURANCE INFORMATION

ALTHOUGH YOUR CHILD MAY QUALIFY FOR THE STATE TO PAY FOR THERAPY SERVICES...

BEFORE THE STATE WILL PAY WE HAVE TO BILL A FAMILIES PRIMARY INSURANCE COMPANY. MANY INSURANCE COMPANIES REQUIRE PRIOR AUTHORIZATION BEFORE WE CAN PROVIDE THERAPY SERVICES.

IF AN AUTHORIZATION IS NEEDED WE NEED YOU, THE PARENT TO CONTACT YOUR CHILDS PHYSICIANS OFFICE TO GET A REFERRAL OR DOCTORS SCRIPT STATING THE NEED FOR THERAPY AND THE CHILDS DIAGNOSIS, FAX OR MAIL TO US AS SOON AS POSSIBLE. MAY WE RECOMMEND THAT YOU MAKE A COPY OF THE REFERRAL FOR YOUR RECORDS. AT THE BEGINNING OF EVERY YEAR THE INSURANCE COMPANY MAY REQUEST A NEW REFERRAL. IT IS VERY IMPORTANT THAT YOU WORK WITH US AND THE PHYSICIAN IN GETTING THIS TAKEN CARE OF.

ONLY AFTER WE BILL THE INSURANCE COMPANIES AND GET A DENIAL WILL THE STATE PAY US. SINCE WE ARE THE THERAPY PROVIDER, WE HAVE TO SEND ALL DENIALS FROM THE INSURANCE COMPANY TO THE STATE TO PROVE THAT THE INSURANCE COMPANY WAS BILLED AND DID NOT PAY THE CLAIM(S).

PLEASE FILL OUT ALL OF THE INSURANCE INFORMATION FORMS. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR OFFICE.

THANK YOU FOR YOU HELP.

ACHIEVEMENT THERAPY SERVICES
BILLING DEPARTMENT

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you as a patient of Achievement Therapy Services, Inc. may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review this notice carefully.

Our commitment to your privacy

Achievement Therapy Services, Inc. is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We are also required by law to provide you with this notice of our legal duties and the privacy we maintain in our practice concerning your health information. We realize these laws are complicated, but we must provide the following important information to you. We also reserve the right to amend or revise this Notice of Privacy Practices as necessary.

Your rights regarding your health information

The health and billing records we maintain are the physical property of Achievement Therapy Services, Inc.. However, the information in these records belongs to you. You have the right to:

1. Request a restriction on certain disclosures and uses of your health information in writing to our office. We are not required to grant the request but we will comply with any request granted;
2. Request that you be allowed to inspect and copy your health record and billing record – you may exercise this request by delivering the request in writing to the office;
3. Appeal a denial of access to your protected health information except in certain circumstances;
4. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
5. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
6. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
7. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and
8. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you would like to exercise any of the above rights, please contact Amy Gallagher, owner, in person or in writing. We will assist you in the steps you should take to exercise your rights.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities that are authorized by law to collect information
2. To health oversight agencies for activities authorized by law. These may include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions: civil administrative and criminal procedures or actions, or other monitoring programs of the government.
3. Lawsuits and similar proceedings in response to a court or administrative order;
4. If required to do so by a law enforcement official;
5. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat;
6. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities;
7. To federal officials for intelligence and national security activities authorized by law;

8. To correctional institutions or law enforcement officials if you are an inmate or under the custody off a law enforcement official; and
9. For Workers' Compensation and similar programs.

Other disclosures and uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Right to a copy of this notice

You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give a copy of this Notice to you at any time.

Right to file a complaint

If you believe your privacy rights have been violated, you may file a complaint with Achievement Therapy Services, Inc. or with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this Notice of Privacy Practices, please contact:

Achievement Therapy Services, Inc.
Attn: Amy Gallagher, OTR, Owner
32531 N. Scottsdale Rd. Ste 105-162
Scottsdale, AZ 85266
480-488-3946 Office
480-488-3956 Fax

I hereby acknowledge that I have been presented with a copy of Achievement Therapy Service's Notice of Privacy Practices.

Signature

Printed Name of Patient

Date

Please return this signed form, Patient Data, and Insurance Information forms to:

Achievement Therapy Services, Inc.
32531 N. Scottsdale Rd. Ste 105-162
Scottsdale, AZ 85266

ACHIEVEMENT THERAPY SERVICES

Occupational, Physical and Speech Therapy

(480) 488-3946 Office

(480) 488-3956 Fax

I authorize Achievement Therapy Services to release the
following medical information/reports

for _____

_____ to _____

Parent Signature & date

Client Data and History

Name: _____ Date of Birth _____

Address: _____

Telephone: _____ Alt. Contact _____

Primary Care Physician: _____

Address: _____

Telephone: _____ Fax: _____

Additional Physicians (include first and last names, specialties): _____

Reason For Referral: _____

Diagnosis/Concerns: _____

Developmental History

Difficulties during pregnancy: _____

Difficulties during labor /delivery: _____

Child was delivered at _____ in _____

(Hospital)

(city, state)

Birth Weight: _____ Apgar Scores (if known): _____ Premature: Yes No # of weeks: _____

Length of stay in hospital: _____ Difficulties with breathing after birth? Yes No _____

Any difficulties during the first two weeks of life? _____

Difficulty with swallowing, sucking, drinking, or chewing? _____

Normal weight gain? Yes No comments: _____

Please list all allergies: Food: _____

Medications: _____

Previous Surgeries (include dates) _____

List Medications currently taking (please spell clearly): _____

Has your child had seizures? Yes No Type of seizures: _____

Has hearing been assessed? Yes No Results: _____

Has vision been assessed? Yes No Results: _____

History of ear infections? Yes No Frequency? _____ Tubes placed ? _____

When did your child first:

Roll over (back to tummy): _____

Sit independently: _____

Crawl: _____

Walk Unaided: _____

Say First Words: _____

Talk in phrases or sentences: _____

Did your baby babble by 6 months of age? Yes No Explain: _____

Did your child eat and drink independently by age 2? Yes No _____

Does your child dress and undress independently? Yes No _____

Is your child toilet trained? Yes No _____

My child sleeps from _____ p.m. to _____ a.m. Naps from _____ p.m. to _____ a.m.

Does your child have tantrums? Yes No Explain: _____

What Behavioral /Discipline techniques work for your child? _____

List all care providers for your child? (i.e. daycare, grandparents) _____

| Insurance Information | | | | | |
|-------------------------------------|-----------|----------------|----------|----------------------------------|------------|
| Patient Name | | Birth date | Age | Sex | SS# |
| Address | | City | | State | Zip code |
| Home Phone | Diagnoses | | | | |
| Father | | Work Phone | Mother | | Work Phone |
| Referred by | | | | Case Manager / DDD Assist Number | |
| Primary Physician | | | | | Phone |
| Primary Insurance Plan | | | Employer | | |
| Policy Holder | | | SS# | Birth date | |
| Address (if different from patient) | | City | | State | Zip code |
| Group # | | ID or Policy # | | | |
| Send Claims to: | | | | | Phone |
| Address | | City | | State | Zip code |
| Secondary Insurance Plan | | | Employer | | |
| Policy Holder | | | SS# | Birth date | |
| Group # | | ID or Policy # | | | |
| Send Claims to: | | | | | Phone |
| Address | | City | | State | Zip code |

MEDICAL INFORMATION RELEASE

I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies or other health care agencies. I also authorize the release of medical records or copies of such and request that they be transferred to Achievement Therapy Services, Inc. 32531 N. Scottsdale Rd. Ste. 105-162 Scottsdale, AZ 85266.

FINANCIAL POLICY

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance. **Patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges.**

CANCELLATION POLICY

If you need to cancel an appointment, we request a 24-hour notice. If you cancel within less than 24 hours of your scheduled appointment, you may be charged for ½ of the scheduled session. If you do not call to cancel and fail to keep your appointment, you will be charged for ½ of the scheduled session. **Insurance will not pay for such "no shows" or late cancellation charges—these charges must be paid by the patient.** If you have 2 or more cancellations within a 4-week period, or 2 or more no shows, we reserve the right to discontinue services.

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to Achievement Therapy Services, Inc..

Signature _____

Date _____

Consent, Release & Assignment

I give permission to Achievement Therapy Services, Inc. and its employees to contact my child's physician to discuss screening results, obtain physician's orders for therapy evaluation and/or treatment.

Child's Physician: _____ Physician Phone Number: _____

Physician Office Name and Address: _____

I consent to Achievement Therapy Services, Inc. to provide evaluation and ongoing therapy services. I understand that evaluation results and therapy recommendations are available to me upon request. Therapies provided are:
____ Occupational ____ Physical ____ Speech-Language.

I authorize the release of information for exchange between Achievement Therapy Services, Inc. the Division of Developmental Disabilities, the physician's office and school records as they apply to the provision of therapies.

I authorize the release of all information in order to process claims for services. I authorize direct payment to Achievement Therapy Services, Inc. Payments received from the HMO or insurance company to the consumer will be forwarded to Achievement Therapy Services, Inc.

I certify the above is complete and accurate account of all medical insurance policies covering my child.

Signature parent/guardian

Date

PRE-SERVICE PROVIDER ORIENTATION

| | | |
|--|---------------|-----------|
| INDIVIDUAL'S NAME <i>(Last, First, M.I.)</i> | SOC. SEC. NO. | BIRTHDATE |
|--|---------------|-----------|

DIET

FOOD:

| | | | |
|---|--|---|---|
| INDEPENDENT WITH UTENSILS <input type="checkbox"/> No <input type="checkbox"/> Yes | INDEPENDENT WITH SPECIFIC UTENSILS <input type="checkbox"/> No <input type="checkbox"/> Yes | REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> No <input type="checkbox"/> Yes | REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> No <input type="checkbox"/> Yes |
|---|--|---|---|

DOES FOOD PRESENT A CHOKING HAZARD

No Yes Required consistency of food Normal Chopped Puréed

SPECIAL DIET

TUBE FEEDING

No Yes Special instructions required

EATING DISORDER

No Yes Describe

BEVERAGES:

| | | | |
|--|---|---|---|
| INDEPENDENT WITH ANY CUP/GLASS <input type="checkbox"/> No <input type="checkbox"/> Yes | INDEPENDENT WITH ADAPTIVE CONTAINER <input type="checkbox"/> No <input type="checkbox"/> Yes | REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> No <input type="checkbox"/> Yes | REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> No <input type="checkbox"/> Yes |
|--|---|---|---|

INDEPENDENT IN OBTAINING/REQUESTING BEVERAGES

No Yes Describe adaptive eating/drinking equipment

IF SPECIAL LIQUID INTAKE NEEDS DESCRIBE

SYSTEM FOR FLUID INTAKE *(If applicable)*

COMMUNICATION

COMMUNICATION SKILLS: *(Check as applicable)*

Uses complex sentences Uses simple sentences Signs Nods yes/no Gestures

DESCRIBE AUGMENTATIVE COMMUNICATION DEVICES *(If applicable)*

MOBILITY

BALANCE WHILE STANDING

Excellent *(not an issue)* Moderate *(stumbles, etc.)* Poor *(very unsteady; falls)*

UTILIZES ADAPTIVE AIDS FOR BALANCE

No Yes

INDEPENDENT MOBILITY *(Check as applicable)*

Crawling/scotting Kneeling Standing Walking Running Climbing

MOBILITY/BALANCE AIDS *(Check as applicable)*

N/A Walker Cane Crutches AFOs Leg Braces Wheelchair Other *(specify)*

POSITIONING INSTRUCTIONS

LIFTING/CARRYING INSTRUCTIONS

PERSONAL CARE SKILLS *(Check all applicable items)*

| | DRESSING | TOILETING | BATHING | DENTAL CARE | MENSES | MED. ADMIN. | OTHER |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Independent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Requires prompting/reminding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Requires limited assistance/supervision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Requires significant assistance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IF APPLICABLE, DESCRIBE SPECIAL PERSONAL CARE NEEDS AND PREFERENCES

BEHAVIORAL CONCERNS *(If applicable)* CIT Training Yes No

| BRIEF DESCRIPTION | APPROXIMATE FREQUENCY | RECOMMENDED INTERVENTION |
|-------------------------|-----------------------|--------------------------|
| Aggression | | |
| Self-Injurious Behavior | | |
| Property Destruction | | |
| AWOL | | |
| Self Stimulation | | |
| Sexual Acting Out | | |
| Other | | |

IS A BEHAVIOR TREATMENT PLAN AVAILABLE FOR ADDITIONAL INFORMATION REASON FOR BTP

No Yes

METHOD USED TO OBTAIN INFORMATION *(In person, case file, etc.)*

SIGNATURES

| | | |
|---|---|------|
| SIGNATURE OF PERSON COMPLETING IF NOT RESPONSIBLE PARTY | RELATIONSHIP | DATE |
| PRINT PROVIDER'S NAME | PROVIDER'S SIGNATURE | DATE |
| PRINT RESPONSIBLE PERSON/GUARDIAN'S NAME | RESPONSIBLE PERSON/GUARDIAN'S SIGNATURE | DATE |

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PRE-SERVICE PROVIDER ORIENTATION

INSTRUCTIONS: This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services. A copy MUST be retained by the provider and a copy sent to the District Office. The provider must also ensure that a General Consent and Authorization form is completed and retained by the provider.

PROVIDER INFORMATION

PROVIDER'S NAME (Print) FEI/SOC. SEC. NO. AHCCCS ID NO.

IS THERE ANY SPECIAL TRAINING REQUIRED

No Yes Describe:

Med Training Needed No Yes Seizure Management Training Needed No Yes

CRITICAL INFORMATION

INDIVIDUAL'S NAME (Last, First, M.I.) SOC. SEC. NO. BIRTHDATE

ADDRESS (No., Street, City, State, ZIP)

GUARDIAN/RESPONSIBLE PARTY'S NAME (Last, First, M.I.) (If applicable) RELATIONSHIP PHONE NO. ()

ADDRESS (No., Street, City, State, ZIP)

EMERGENCY CONTACT'S NAME (If other than responsible party) RELATIONSHIP PHONE NO. ()

SUPPORT COORDINATOR'S NAME OFFICE LOCATION PHONE NO. ()

NAME OF ALTCS/DDD HEALTH PLAN AHCCCS ID NO. PHONE NO. ()

PRIMARY CARE PHYSICIAN'S NAME PHONE NO. ()

ADDRESS (No., Street, City, State, ZIP)

URGENT CARE FACILITY'S NAME PHONE NO. ()

ADDRESS (No., Street, City, State, ZIP)

OTHER HEALTH INSURANCE INFORMATION

DAY PROGRAM (If applicable)

NAME OF DAY PROGRAM PROGRAM TYPE DAYS AND HOURS OF ATTENDANCE TRANSPORTATION METHOD

DAY PROGRAM ADDRESS (No., Street, City, State, ZIP) PHONE NO. ()

HEALTH - MEDICAL

CURRENT MEDICATIONS AND SIGNIFICANT HISTORICAL MEDICATION ISSUES:

MED LOG REQUIRED No Yes SPECIAL MEDICATION INSTRUCTIONS

ALLERGIES TO:

Food? No Yes Specify Medication? No Yes Specify

Bee Stings? No Yes Other? No Yes Specify

RECOMMENDED RESPONSE TO ALLERGIC REACTION

SEIZURES: No Yes

DESCRIBE FREQUENCY APPROXIMATE DURATION

RECOMMENDED RESPONSE TO SEIZURE ACTIVITY

ASSISTIVE DEVICES:

VISION HEARING DENTAL APPLIANCES

PROTECTIVE DEVICES:

INSTRUCTIONS FOR USE PURPOSE

OTHER INDIVIDUALIZED HEALTH CARE ROUTINES

Distribution: White - Provider; White- District Office; Canary - Parent/Guardian; Pink - Support Coordinator

I have reviewed the Pre-Service Providers Orientation form for the following child and I understand the personal information it provided.

Client: _____

Therapist: _____

Date Reviewed: _____

Date Updated & Reviewed: _____

Date Updated & Reviewed: _____



Dear Parents/Caregiver's,

Effective immediately our sick policy is changing.

You must call to notify your child's Therapist if your child has been ill within the last 48 hours. Examples include vomiting, diarrhea, rashes, conjunctivitis "pink eye" cold or flu symptoms, etc. It will then be up to the Therapist as to reschedule or see your child. This new policy is in efforts to protect the health of all of our clients and Therapists. We appreciate your cooperation. Thank you.

Achievement Therapy Services.

Clients Name: _____

ACHIEVEMENT THERAPY SERVICES STATEMENT OF RIGHTS

All services provided by Achievement Therapy Services follow the Department of Economic Security Division of Developmental Disabilities chapter 1500 Individual Rights and Responsibilities guidelines. This statement of rights discusses basic rights related to the provision of rehabilitation. Specific rights in this form are not meant to be all-inclusive:

- 1). the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part creating and changing the plan and evaluating care and services;
- 2). the right to be told in advance of receiving care about the services that will be provided the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices are available;
- 3). the right to be told in advance of any changes to the plan of care and to take an active part in any change;
- 4). the right to refuse services or treatment;
- 5). the right to know, in advance, any limits to the services available from a provider, and the providers grounds for a termination of services;
- 6). the right to know that there may be other services available in the community, including other home care and rehab services and providers, and to know where to go for information about these services;
- 7). the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, AHCCCS, or other health programs;
- 8). the right to have personal, financial, and medical information kept private; and to be advised of the providers policies and procedures regarding disclosure of such information;
- 9). the right to be allowed access to records and written information from records;
- 10). the right to be served by people who are properly trained and competent to perform duties;
- 11). the right to be treated with courtesy and respect, and to have the patient's property with respect;
- 12). the right to be free from physical and verbal abuse;
- 13). the right to voice grievances regarding treatment or care that is, or fails to be, furnished, or regarding the lack of courtesy or respect to the patient or the patient's property;
- 14). the right to know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigated and attempt to resolve the grievance or complaint;
- 15). the right to know the name of the state or county agency to contact for additional information or assistance and;
- 16). the right to assert these rights personally, or have them asserted by the patient's family or guardian when the patient has been judged incompetent without rehabilitation.

THESE RIGHTS ARE THE ESTABLISHED FOR THE BENEFIT OF PERSONS RECEIVING HOME CARE AND/OR THERAPY SERVICES AND MUST BE PROVIDED TO AN INDIVIDUAL AT THE TIME SERVICES ARE INITIATED.

YOU HAVE THE RIGHT TO COMPLAIN TO THE LICENSEE ABOUT THE SERVICE YOU RECEIVE. YOU MAY CONTACT THE PERSONS LISTED BELOW IN WRITING OR BY PHONE. THE LICENSEE SHALL TAKE NO

ACTION THAT NEGATIVELY AFFECTS A CLIENT IN RETALIATION FOR A COMPLAINT MADE BY THE CLIENT.

CONTACT

Amy B. Gallagher
32531 N. Scottsdale Rd. Ste 105-162
Scottsdale, Az 85262
(480) 488-3946 Office
(480) 488-3956 Fax

YOU ALSO HAVE THE RIGHT TO COMPLAIN TO THE FOLLOWING OFFICE:

Division of Developmental Disabilities
Compliance and Review Unit
P.O. Box 6123 Site Code 791A
Phoenix, AZ 85005

I CERTIFY THAT I HAVE BEEN INFORMED AND UNDERSTAND THE ABOVE STATEMENT OF RIGHTS, OF WHICH THE PROVIDER HAS PROVIDED A COPY TO ME.

SIGNATURE OF RECIPIENT OR GUARDIAN

DATE