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 Consents and Authorization Forms – 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.
- Family Guide to Therapy – this is general information about our office for you to read and keep at home.
- HIPAA Privacy Notice – for your review and files.

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

Office	Phone	Fax	Email
Alexandria	540-720-2261 Ext 2	540-720-5660	Alexandria@flemingtherapy.com
Chantilly	540-720-2261 Ext 3	540-720-5660	Chantilly@flemingtherapy.com
Fredericksburg	540-720-2261 Ext 5	540-720-5660	Fredericksburg@flemingtherapy.com
Glen Allen	540-720-2261 Ext 8	540-720-5660	Glenallen@flemingtherapy.com
Lorton	540-720-2261 Ext 7	540-720-5660	Lorton@flemingtherapy.com
Stafford	540-720-2261 Ext 4	540-720-5660	Stafford@flemingtherapy.com
Woodbridge	540-720-2261 Ext 6	540-720-5660	Woodbridge@flemingtherapy.com

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.

Please check out our website at www.flemingtherapy.com to learn more about us. The website can also provide you with a map and directions to the office.

Enthusiastically,

The Staff at Fleming Therapy Services

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 Therapy	
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**

Theraplay, Inc.

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
Please list your child's grade and name of school		
Does your child have an IFSP/IEP/504 Plan?	If Yes, please provide a copy	
Has your child previously received or currently receiving behavioral services?	☐ yes	☐ no
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 or Specialist? ☐ yes ☐ no

If yes, who, what discipline and where?

What is the primary language spoken at home?

THERAPY GOALS

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

Physical Therapy Additional Information Sheet

Please complete this section completely
Do you have any concerns with the following? (if so please explain):
Amount of time your infant (0-12 months) spends in devices such as car seat, bouncy seat, swing, exersaucer:
Tummy time or developmental skills:
Posture:
Walking or Running:
Balance or Coordination:
Endurance or ability to keep up with peers:
Pain or orthopedic injury:
Adaptive Equipment (orthotics, wheelchair, gait trainer):
Additional Comments/Concerns:

Occupational Therapy Additional Information Sheet

Please complete this section completely
Do you have any concerns with the following? (if so please explain):
Sensitivity to messy play, textures, lights or sounds:
Over or under enjoying movements, such as swinging or spinning:
Using both hands for lifting, carrying or manipulating objects:
Clumsiness or tripping frequently:
Eye contact:
Social skills (such as body awareness, taking turns, and staying on-topic):
Sustaining focus for play or school activities:
Reading comprehension, organization of tasks, or remembering details:
Discriminating shapes, colors, letters or numbers:
Copying shapes/colors/designs:
Dressing/Undressing (buttons, zippers or snaps):
Using utensils, writing instruments, or scissors:
Transitioning between activities (i.e. needs to be prepared):
Please list any classroom skills your child's teacher has reported are concerns.
Additional Comments/Concerns:

Speech and Language Therapy Additional Information Sheet

Please complete this section completely
Do you have any concerns with the following? (if so please explain):
Articulation (i.e. difficulty saying specific sounds or hard to understand): **Please estimate in a percentage how much you are able to understand what your child says.**
Ability to use language and words to communicate:
Eye contact:
Social skills – Describe how your child interacts with **Children:** **Adults:**
Imitating sounds and/or actions:
Reading comprehension:
Written language (i.e. generating stories):
Answering questions -Describe how your child answers: **yes/no questions:** **"wh" questions (what/where/when/who/why):**
Comprehension: **How does your child follow 1-step directions?** **How does your child follow 2-step directions?**
The quality of sentences your child is able to form:
Does your child use any alternative modes of communication (i.e. sign /AAC devices, PECS)?
Additional Comments/Concerns:

Feeding Therapy Additional Information Sheet

Please complete this section completely

Has your child been tested for allergies? Reflux? Had a swallow study?

Does your pediatrician or specialist have any concerns with weight or growth of your child?

What is the current method of feeding?

___________NPO ___________PO ___________NG tube ___________G tube ___________GJ tube

Was your child successful with a bottle?

Problems observed:

When did your child begin solids? (cereal, baby food)

Did your child progress through solids?
Check all that apply:

____Baby cereal____Stage 1_____Stage 2 _____ Stage 3___Purees ___Soft chewables_____Hard chewables

Does your child drink a variety of liquids?
Which ones:

When?_______before ___during ___after meals

Via:________bottle____sippy cup____drink box____open cup _____straw

Is your child able to self-feed?

With:_______fork____spoon____finger feed

Is there any spillage when using utensils?

What is your child's arousal level during feeding?

_____deep sleep______light sleep____drowsy__________quiet/alert____active/alert___crying Other:

Describe:

What behaviors does your child exhibit during feeding?

Does your child receive supplemental feeding?

If yes, describe:

How long is each meal?

Describe the environment where your child usually eats (such as room, type of chair, music/tv on)

Does your child eat more/less (circle one) foods in different environments, in school, outside events, etc.?

Does your child eat same/different (circle one) foods in different environments?

Please describe:

Please list your child's favorite foods to eat

Feeding Therapy Additional Information Sheet – Page 2

Please list any foods that your child refuses

If different from your child's refused foods, please list foods that are difficult for your child to eat.

Is there a texture/consistency that your child prefers?

___puree____lumpy____crunchy____liquids____chewy____other:_

Is there a texture/consistency that your child dislikes or refuses?

___puree____lumpy____crunchy____liquids____chewy____other:_

Feeding schedule:

Breakfast: Time:
Foods: please list:

Lunch: Time:
Foods: please list:

Dinner: Time:
Foods: please list:

Snacks: Times:
Foods: please list:

Please list any evaluations and or treatments if you have previously tried to help your children with his/her problem

Please describe any other comments about your child's feeding

What are your goals for your child in regards to their feeding?

We appreciate your time and participation in helping us provide a thorough feeding evaluation for your child.

Suggested items to bring to the evaluation:

- **Previous feeding evaluation reports (i.e. swallow studies) GI evaluations**
- **Any special seating equipment for feeding time**
- **Typical utensils used for feeding (bottle, cup, fork, plate, etc.) Unsuccessful or refused food items**
- **Preferred food items**
- **Variety of textured foods— Purees (baby foods, applesauce, pudding, etc.) Soft chewables (cooked vegetables, etc.) Hard/crunchy chewables (cereal, crackers, chips, etc.)**

Patient Name:

Consent to Treatment and Authorization for Release of Information

I hereby authorize Fleming Therapy Services 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 Fleming Therapy Services to request appropriate information from my child's physicians. I further authorize Fleming Therapy Services to release any pertinent information to these physicians. I have read and understand the above consent.

Parent/Guardian Signature: Date:

Patient Supplemental Informed Consent

As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal precautions and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your local grocery store or in the community. "Social Distancing" nationwide has reduced the transmission of the coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, therapist and sometimes other patients at all times.

I hereby authorize Fleming Therapy Services 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 while maintaining social distancing and required personal protective equipment. I understand that while exposure is unlikely, I accept the risk and consent to treatment. I authorize Fleming Therapy Services to request appropriate information from my child's physicians. I further authorize Fleming Therapy Services to release any pertinent information to these physicians. I have read and understand the above consent.

Parent/Guardian Signature: Date:

Telehealth Consent to Treatment and Authorization for Release of Information

I hereby authorize Fleming Therapy Services 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 Fleming Therapy Services to request appropriate information from my child's physicians. I further authorize Fleming Therapy Services to release any pertinent information to these physicians.

I authorize payment directly to Fleming Therapy Services 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.

To maintain HIPAA privacy, it is best that our patients do not receive services in a public setting. If that is necessary, the therapists will do their best to implement reasonable HIPAA safeguards – such as but not limited to – using lowered voices, not using a speakerphone, or recommending that the patient moves to a reasonable distance from others when protected health information (PHI)I s being discussed. This will aim to limit incidental uses or disclosures of PHI.

Parent/Guardian Signature: Date:

Patient Name:

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I can print off a copy of Fleming Therapy Services'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 Fleming Therapy Services, 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:

There is nothing below this section

Consent to Communicate Health Care Information

Patient Name:

Due to Fleming Therapy Services, 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 Fleming Therapy Services, to leave messages regarding insurance/billing matters with anyone who answers my home phone.

_____________ I authorize the staff of Fleming Therapy Services, to leave messages regarding insurance/billing matters on my home or cell phone voicemail.

_____________ I authorize the staff of Fleming Therapy Services, to leave messages regarding insurance/billing matters at my place of employment, using the telephone number provided by me.

_____________ I authorize the staff of Fleming Therapy Services, to leave messages regarding appointments with anyone who answers my home phone.

_____________ I authorize the staff of Fleming Therapy Services, to leave messages regarding appointments on my home or cell phone voicemail.

_____________ I authorize the staff of Fleming Therapy Services, to leave messages regarding appointments at my place of employment, using the telephone number provided.

_____________ I authorize the staff of Fleming Therapy Services, to email using the email address provided by me.

_____________ I authorize the staff of Fleming Therapy Services, to leave messages regarding therapy matters with anyone who answers my home phone.

_____________ I authorize the staff of Fleming Therapy Services, to leave messages regarding therapy matters on my home or cell phone voicemail.

_____________ I authorize the staff of Fleming Therapy Services, 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: __________________________________

AOT SPECIALIZED EDUCATIONAL THERAPY SERVICES AUSTILL'S Educational Therapy Services THERAplay The Children's Therapy Center FLEMING THERAPY Therapy In Sync Positive Steps

Family of Companies

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 Fleming Therapy Services, the right and permission, with respect to the photographs and videos
Initials 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 Fleming Therapy Services, 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: ____

____

____

THERAplay inc.

WELCOME TO FLEMING THERAPY SERVICES. Thank you for the opportunity to work with you and your child. All of us here at Fleming Therapy Services 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.

Alexandria Office

Center Manager: Caitlyn Crnkovich DOT, OTR/L
Front Desk Coordinator: Renee Eldridge

Chantilly Office

Center Manager: Kayleigh Holzer MOT, OTR/L
Front Desk Coordinator: Meskela Michael

Fredericksburg Office

Center Manager: Courtney Soper MS, OTR/L
Front Desk Coordinator: Jeanette Sullivan

Glen Allen Office

Center Manager: Caitlin Beam, PT, DPT
Front Desk Coordinator: Samantha Stahl

Lorton Office

Center Manager: Tracy Capili OTD, OTR/L
Front Desk Coordinator: Taimi Schweighardt

Stafford Office

Center Manager: Kaitlyn Glass, PT DPT
Front Desk Coordinator: Amanda Stevens

Woodbridge Office

Center Manager: Courtney Romanowski MS, CCC-SLP
Front Desk Coordinator: Sonia Renderos

Corporate Administration

Carrie Fleming M.ED CCC-SLP, Executive Vice President, (540) 720-2261 Ext 172, office@flemingtherapy.com
Samantha Gorrell, PT, DPT, Vice President of Outpatient Operations, (215) 259-2767, sgorrell@theraplayinc.com
Jennifer Bass MA CCC-SLP, Associate Director of Outpatient Services, (540) 720-2261 Ext 7, jennifer.bass@flemingtherapy.com
Elana Graves, Director of Front Desk Operations, (484) 370-2170, egraves@theraplayinc.com
Billing Department, 540-720-2261 Ext 1, office@flemingtherapy.com

Center Addresses and Phone Numbers can be found on our website

flemingtherapy.com

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 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, and credit cards. 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. We believe 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.

Telehealth Guidelines

1. When telehealth takes place in a setting that is not private and the parent/guardian will not be accompanying the patient during therapy:
   - Parent/guardian must sign the Authorization to Disclose Patient Health Information (PHI Form) for the individual(s)/organization whom they are authorizing to oversee the patient during our treatment sessions
   - Parent/guardian must also sign the Minor Consent for patients under the age of 18, if the authorized individual(s) are allowed to leave the patient unsupervised - for any portion of the telehealth session
2. Prior to each telehealth visit, please pay any co-payment that is required by your insurance through our "Pay Your Bill" link on our website.
3. Download the digital application we will be using for our visit on your phone or computer. We will be using Zoom and you will need audio and visual.
4. Some other guidelines to consider:
   - Dress in comfortable clothing that you can easily move in.
   - Find a space that is quiet
   - Have good lighting either with a floor lamp next to you, be near a window during the day, or good overhead lighting
   - Ask other members of the house to not be downloading or streaming to other digital devices so your connection will not be slowed down

SCHEDULING GUIDELINES

1. All therapy is by appointment only.
2. When scheduling appointments, you may schedule up to one month (30 days) 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 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 we are 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 our care 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. We strive to maintain your child's and family's confidentiality at all times, including social media. We encourage you to "like" our Facebook page to keep up to date on Company news and 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

We respectfully request that family members, caregivers, and those providing care and/or support to our patients 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

We respectfully request that clients, family members, caregivers, and so forth not bring contraband into our 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 center violates the environment 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, whooping cough and Covid-19 related symptoms.

COVID-19 GUIDELINES

If your child or any family member is/has been feeling sick, please stay at home and call our offices to cancel the appointment. We ask that you do not reschedule for 48 hours.

We strongly encourage the following practices to help reduce the spread of illness as recommended by the CDC:

- Avoid close contact with people who are sick;
- Avoid touching your eyes, nose, and mouth;
- Stay home when you are sick, such as with new onset of cough, cold or running nose;
- Cover your cough or sneeze with a tissue or in the nook of your elbow (NOT your hands), then dispose of directly in a trash receptacle;
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or sanitization wipe;
- Follow CDC's recommendations regarding the use of a facemask;
- Wash your hands often with soap and water for at least 20 seconds, especially after using the restroom, before eating, and after blowing your nose, coughing, or sneezing;
  - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

We have instituted new procedures for the arrival/departure of clients, collection of fees/co-pays, admittance to the center as well as social distancing etiquette during the sessions.

Precautions Taken at Our Centers

- All staff will be screened prior to entering the clinic daily (temperature and symptom screening).
- All patients will be screened prior to each clinic visit. Should we identify any risk, the appointment will be rescheduled.
- Each therapist will be required to wear masks and gloves while treating patients.
- All equipment, common areas, entry and exit doors and access areas will be sanitized routinely.
- All highly touched items (brochures, magazines) are removed from the waiting area.
- Any patient with a compromised immune system or other high-risk conditions, is encouraged to speak with their physician and therapist for proper guidance as to whether it is recommended to attend in-clinic therapy, utilize telehealth, or postpone treatment to a later date.
- All therapeutic areas will continue to be sanitized before, during and after each patient.

Before the Session

- It is encouraged that your child wears a face mask during any contact with our staff, and during the session. If your child will not tolerate a face mask, please discuss your situation with the center manager. It is required for anyone attending therapy with the child, to wear a facemask during sessions. These will not be provided by us and will need to be supplied by you.

Arrival to Your Session

- We ask you arrive to the location 10 minutes before your appointment.
- Only the **child attending the session and one (1) family member** (parent/guardian) are allowed inside the center in order to ensure social distancing and to limit occupancy in the building.
    - Please inquire with your center for the patient arrival procedures. These will differ based on the center layout.
- You and your child will be asked the following screening questions and triage before every session. We will also take the temperature of you and your child prior to the visit starts. Any temperature above 100.4 degrees will result in the visit being cancelled.
    - Has any member of your household been feeling ill or exhibited any symptoms in the past few days?
    - Are you aware that you have been in close contact (within 6 feet for 10 or more minutes) with anyone with confirmed COVID-19 in past 14 days without a mask?
    - Do you have a new cough?
    - Are you having trouble breathing/experiencing shortness of breath?
    - Do you have any unexplained muscle pains or rashes?
    - Are you awaiting results from a COVID-19 test?

Waiting Room

- In order to maintain social distance, we have decreased the number of chairs in the waiting room and have spaced them out.
- We have center specific procedures in place to ensure appropriate social distancing.
- The front desk window(s) will be restricted in their opening to limit interactions. It will only be opened for the exchange of paperwork and patient payment collections. You can complete payments through our website if you prefer. If you wish to discuss any confidential matter, please call the center.

The responsible adult bringing the child to session must remain in the premises during the whole time the child is in session. This include staying inside your car with access at all times to the phone, or in the waiting room if directed by the staff.

During the Session

We believe that the involvement of the parent/guardian during the therapy session is key to ensure the child achieves his/her goals. However, in order to respect social distancing, we will be limiting the number of people inside the center and treatment areas.

- Your therapist will notify you if your presence is necessary during the session; or
- You may be asked to enter the building at a specific time assigned by the therapist to discuss the treatment plan/session as appropriate.
- Social distance during the sessions:
    - Therapist may make modifications during session when it is safe and appropriate.
    - Sessions have been scheduled in order to maintain only the safe amount of people in the treatment rooms and gym areas.

Cleaning and Disinfecting Procedures

We continue to follow our strict procedures as far as cleaning and disinfecting our equipment, as well as adhering to CDC, federal, state and local guidelines.

- Any equipment or toy that comes in contact with the child will be removed after the session to be thoroughly cleaned and disinfected.
- Any equipment or toy that cannot be satisfactorily cleaned and disinfected in a timely matter per our policy and procedures has been removed from the treatment areas – this includes pillows, sensory bins, etc.
    - If such toy/equipment is required for the treatment session, your therapist will inform you of alternative options or accommodations.

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