30 Avon Meadow Lane
Avon, CT 06010
Ph:860-284-9779/Fax:860-409-2190

Welcome to Creative Development, LLC!

We appreciate the opportunity to work with you and your child. Please read through and complete all paperwork before your arrival. We ask that you please **arrive 15 minutes prior** to the start of your appointment. Use the checklist below to ensure all necessary forms have been completed and reviewed. After completion of this packet, please sign below and return to Creative Development, LLC at the time of your evaluation.

Thank you for your confidence in the Creative Development team and we look forward to working with you and your family.

This packet includes the following & a copy will be emailed to you following your initial visit:

- ☐ Financial Policies
- ☐ Developmental Milestones & General Health Form
- ☐ Food Permission/Dietary Information Form
- ☐ Video & Picture Release
- ☐ Educational/Teaching Release
- ☐ Attendance, Cancellation, Mandatory Reporting & Acknowledgement of Risk Policies
- ☐ Patient Information Form
- ☐ Consent to Release Information
- ☐ Notice of Privacy Policies and Practices
- ☐ Notice of Privacy Practices/Clinical Policies Acknowledgement of Receipt Form
- ☐ Authorization For Payment of Services Form

My signature below is confirmation I have received and read all necessary paperwork and I agree to all terms and conditions. I further acknowledge I have informed Creative Development, LLC of all necessary information and have answered all questions truthfully and to the best of my ability.

________________________	____________________________
Child's Name	**Parent/Guardian Name Printed**
________________________	___________________
Parent/Guardian Signature	**Date**

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Financial Policies

We currently participate with Anthem BCBS, BCBS, United Health Care, Harvard Pilgrim, Aetna , CIGNA, Connecticare and HUSKY. Participation in these insurances is *not* a guarantee of payment. Payment for services is due at the time services are rendered.

Returned checks are subject to a $30 fee. Sessions canceled with less than 24-hour notice of my scheduled appointment, or in the event of a no call/no show for an appointment 2 consecutive times or more is subject to a non-refundable $50 cancellation fee with an additional fee after each subsequent visit of cancellation less than 24 hour or no show.

If you have a deductible through your insurance plan, we require a $50 deposit prior to initiation of services.
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If Creative Development, LLC is **not** a participating provider of my insurance company, I am responsible for the full payment of the evaluation/treatment session at the time of service. I am then able to submit my bill to my insurance provider for coverage. The clinic will provide a statement that includes all of the necessary information for submission of my claim (such as a diagnosis, procedure codes, dates of service, and this clinic's tax identification number) upon request.

I agree to place a credit card on file, prior to initiation of services, in the event that payment is not rendered at time of service.

We are able to provide a brief, abridged evaluation report for the insurance companies. This includes only one basic assessment for the purpose of insurance coverage. This does NOT include specialized standardized assessments, comprehensive evaluation reports or a parent meeting. **Please see "Private Pay Fee Schedule" for evaluations and services NOT covered by insurance**. Please note that most benefit plans have limits on the number of treatment sessions/the length of time you are allowed to receive services. You are responsible for knowing your coverage and annual visit limit. Other ***therapeutic consultations*** (such as home, school, daycare, and work-site visits, travel, additional reports and phone consultations) will be charged according to the clinic's private pay fee schedule. If an outside agency/school system pays for treatment but does not authorize payment of reports or meetings, I understand that I may be billed for these separately.

I am responsible for payment if my insurance plan denies coverage. Insurance companies can deny payment for services even after they have authorized visits dependent on the insurance plan. The decision to pay for services is made by the insurance company when the claim is received, and is based upon the insured person's eligibility on the date of service.

I have read the above information and understand that as parent/guardian, I am ultimately responsible for payment of all services provided by Creative Development, LLC.

Signature ____**Date**________

Development and General Health

Question	NO	YES
Was your child born before 37 weeks?	NO	YES. Please specify:
Did your child spend time in the NICU?	NO	YES. Please specify:
Were there any complications, illnesses or stress during pregnancy?	NO	YES. Please specify:
Did your child require medical treatment after birth?	NO	YES. Please specify:
Has your child received any therapy services in the past?	NO	YES. Please specify:
Does your child have a medical diagnosis?	NO	YES. Please specify:
Does your child currently take any medications?	NO	YES. Please specify:
Has your child experienced any major injuries or hospitalizations?	NO	YES. Please specify:
Has your child had problems with his/her ears or hearing?	NO	YES. Please specify:
Does your child wear glasses?	NO	YES. Please specify:
Has your child had or is she/he scheduled for any additional tests regarding chief complaint(s)? (MRI, swallow study, hearing test, etc.)	NO	YES. Please specify:
Does your child have a history of seizures?	NO	YES. Please specify:
Does your child have seasonal/environmental allergies?	NO	YES. Please specify:

Developmental Milestones
(Please give approximate ages or comment on anything unusual)

Rolled over ____________________

Sat alone_____________________

Crawled_______________________

Walked_____________________

Chewed food_________________

Drank from open cup_______________

Said words___________________

Said sentences____________________

Finger fed ___________________

Used utensils _____________________

Dressed self ______________

Slept through the night _______________

Babbled _________________

What do you love most about your child? ____

What do you hope to accomplish with therapy? What are your goals for your child?

What is your child's favorite play activity?

____

What are your long-term goals for your child? (does not have to be specific to therapy)

____

Food Permission/Dietary Information

Please list any allergies your child may have, including food, non-food and/or latex:

____

Please complete the following to allow your child to participate in snack/meal preparation activities:

_________ My child may participate in snacks and has no diet restrictions.

_________ My child may participate in snacks with the following diet restrictions/allergies:

Dietary Restrictions: ____

________ My child may particpate in snacks; however, I will provide the snack.

________ My child may **not** participate in snack time.

Please list the food(s) your child is motivated to eat: ____

____

Video and Picture Release

____ I give permission for my child's picture/video to be used by Creative Development, LLC for the purpose of training other professionals.

____ I give permission for my child's picture to be used by Creative Development, LLC for marketing/publicity.

___I do **not** give permission for my child's picture/video to be used for any purpose other than training his/her specific clinical team or for therapeutic purposes.

Educational/Teaching Release

Creative Development LLC is a teaching facility consisting of both therapists and interns looking to expand upon their knowledge and repertoire of services. This participation on the part of the students is essential in their becoming certified therapists.

____I give permission for college therapy students and volunteers to observe my child's therapy sessions.

____ I give permission for college fieldwork students to participate, develop and implement treatment sessions under the guidance of my child's therapist, as appropriate.

___I do **not** give permission for college therapy students/volunteers to be present in my child's therapy sessions.

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******PLEASE KEEP FOR YOUR RECORDS*******

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Attendance Policies

Arrival Time: Please arrive 5-10 minutes prior to your scheduled appointment. Children will only be seen for the allotted therapy time. Children that arrive 15 or more minutes late for an appointment will be seen or rescheduled as appointments are available.

Departure Time: We request that you be available 10 minutes PRIOR to the end of your child's therapy session so your child's therapist may talk with you and educate you on home programs. If you are unavailable 10 minutes prior to the end of the treatment session or arrive late to pick up your child, staff will not be able to address your home program or questions as they have other children to see.

Parents/guardians may leave CD during their child's treatment sessions **only if** a cell phone number has been provided to reach you.

Consultation Policies

CD therapists are available to meet with your child's educational or treatment team outside of a normal treatment session. These consultations are charged at the rate of an individual session. These include school consultation visits, PPT meetings and other community based meetings with other professionals regarding your child's treatment. **Please refer to private fee schedule for therapeutic consultation rates not covered under your insurance.**

Cancellation Policies

Creative Development, LLC understands there are times when families need to cancel therapy appointments. We request that when possible, families provide at least 24 hours notice when therapy appointments must be cancelled. For cancellations please call the office at 860.284.9779 or send an email to info@creativedevelopmentct.com. If no one is available to answer the phone, please leave a message on the voicemail, available 24 hours/day.

In order to allow us to meet the needs of all children seen at CD, we have attendance policies that, if violated, will require us to cancel all previously scheduled appointments with possible discontinuation of services. This includes:

1. **Missing 2 or more appointments with less then 24 hours notice within a 30-day period will result in a $50 cancellation fee with each consecutive cancellation resulting in an additional fee.**
2. **2 "no shows" at any given point. Please note that the 2nd" no show will result in a $50 cancellation fee.**

These attendance issues will result in losing your regularly scheduled appointments and your child will be scheduled on a weekly basis as the schedule provides availability.

Sick Policy

For the health of our staff and all other families who attend Creative Development, LLC, please call and cancel your appointment if you or your child(ren) have ***any*** of the following symptoms including: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red/running eyes. Children/families must be fever and symptom free for 24 hours before resuming services.

Inclement Weather Policy

Creative Development, LLC is open except in cases of severe weather conditions requiring businesses to close.

In the event that the CD office is closed or has a delayed opening due to inclement weather, please contact us to reschedule your appointment. Please check WFSB Channel 3 and NBC 30 for delays and closures in addition to our website (www.creativedevelopmentct.com) and by calling 860-284-9779 for a recorded message.

Families may cancel treatment if they do not wish to travel due to poor road conditions. Clients WILL NOT be charged a cancellation fee due to inclement weather cancellations. Please contact the office if you choose to cancel your child's appointment.

Mandatory Reporting

As providers of services for children, **ALL** parents/guardians, therapists and staff are mandated to report to DCF after indication of abuse or neglect of a child or indication that the child(ren)/family are at risk of potential harm or are in imminent danger. (Abuse=verbal, physical, and/or emotional) All staff are mandatory reporters; staff will not violate confidentiality unless clinician believes client is in imminent danger or at risk of harm to self or others.

Acknowledgement of Risk

There is some risk inherent in the use of the therapy equipment at this clinic, Creative Development, LLC is harmless from any and all losses and claims for any injuries or other damages that may occur from the use of therapeutic equipment. The CD staff have established rules of safety and conduct and abides by these standards.

I have read and understand the above policies.

______________________________ ______________

Parent/Guardian Signature **Date**

PATIENT INFORMATION FORM ALLERGY ALERT:
PLEASE COMPLETE ENTIRE FORM.

PATIENT: (THIS SECTION REFERS TO PATIENT ONLY)

Client's Name:				
Address:				**Birth Date:**
City:	**State:**	**Zip:**	**School:**	
Home Phone (including area code):			**Grade:**	
Parent/Caregiver cell phone:			**Parent/Caregiver cell phone:**	
Emergency Contact (EC):			**EC Relationship:**	**EC Phone #:**
Primary Care Physician:				

FILL IN IF PATIENT IS A MINOR

Parent/Guardian Name:	**Date of Birth:**	**Parent/Guardian Name:**	**Date of Birth:**
Address (if different from client):		**Address (if different from client):**	
Email:		**Email:**	

INSURANCE

Primary Insurance Co.:		**Secondary Insurance Co.:**	
Subscriber's Name:		**Subscriber's Date of Birth:**	
Employer		**Employer's Phone:**	
Employer Address:		**Plan:**	
Policy #:	**Group #:**	**Policy #:**	**Group #:**
Copay Amount:		**Copay Amount:**	

I authorize my physician, health care provider, and their representatives to release any information relating to an illness, injury, diagnosis, care or treatment to my insurance company, health plan, Medicaid, or third party payor or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including: psychiatric, psychological, nervous/mental, substance abuse (e.g. alcohol and drug abuse) and HIV and HIV-related information. I understand that the reason for furnishing such information may include the following: for use in medical, financial or provider auditing, or such other auditing as may be legally required, for utilization and/or quality of care review and assessment and for determining available health benefits and coverage.

____

Patient's/Parent's/Legal Guardian's signature and Date

Coordination of Care/Consent to Obtain and Release Information

Client Name: ____ DOB: _____________

We understand the importance of coordinating and communicating with other persons involved in your child's development. Please list any other professionals working with your child with whom you would like us to collaborate with.

Name:_________________________ Contact Info:_______________________________

Name: ________________________ Contact Info: _______________________________

Name:_________________________ Contact Info:_______________________________

Name: ________________________ Contact Info: _______________________________

Name:_________________________ Contact Info:_______________________________

Name: ________________________ Contact Info: _______________________________

I understand that the information being obtained/released is for the purpose of treatment planning. I understand that I may withdraw this consent at any time prior to the release of the above information and that withdrawal of this consent must be done in writing. I understand that refusal to grant consent will not impede my right to obtain present/future treatment so long as the disclosure is not deemed as necessary for providing appropriate clinical care.

<u>This consent will expire 1 year from the date of signature.</u>

Parent/Guardian Signature: ______________________________ Date _____________

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Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about your child may be used and disclosed; and how you may obtain access to this information. Please review it carefully!

With your consent, the CD practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include: documentation of your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A therapist obtains treatment information about you and records it in a health record. During the course of your treatment, a treatment plan is developed and updated. This treatment plan is modified and available in your child's chart in order to carry out therapy goals provided by your child's therapist(s) at Creative Development.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us to determine whether the services are considered medically necessary. We will provide information to them about you and the care that is provided.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health records and billing records we maintain are the physical property of the practice. The information in it, however, belongs to you. You have the right to:
• Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
• Obtain a paper copy of this *Notice of Privacy Practices for Protected Health Information* (“Notice”) by making a request at your office;
• Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
• Appeal a denial of access to your protected health information except in certain circumstances;
• Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
• 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;
• 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;
• 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,
• 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 want to exercise any of the above rights, please contact Creative Development, LLC in person or in writing, during normal hours. We will assist you on the steps to take to exercise your rights.You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Other Responsibilities
We will:
• Maintain the privacy of your health information as required by law;
• Provide you with a notice of our duties and privacy practices as to the information we collect and notify you if we cannot accommodate a requested restriction or request;
• Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our *Notice.* You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our *Notice* or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Creative Development.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at the office for Civil Rights, US Department of Health and Human Services.

Public Health:
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings:
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses:
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website:
If we maintain a website that provides information about our entity, this Notice will be on the website.

Client Name:_________________________

AUTHORIZATION FOR PAYMENT OF SERVICES

Credit Card: (Please circle one) Visa Mastercard Discover Card HSA Credit Card

Credit Card Number: ________________________________
Expiration Date: ___________ V-Code #: _____ (last 3 digits on the back of card)

Name on Credit Card: ______________________

Billing Address: ____

Phone #: ________________________ Email: ____________________________________

I, _______________, as the owner or person with signature rights, hereby certify that I agree to pay using check, cash or credit card. I agree to place a credit card on file and to use this credit card number for the purpose of payment for services rendered by Creative Development, LLC according to financial policies. If insurance does not cover services and/or payment is not received within 30 days of receipt of invoice, I understand my credit card will be charged.

In the event that this credit card becomes expired or invalid, I will with a check, cash or current credit card for the payment of any outstanding balances owed to Creative Development, LLC. I also understand that I have the right, at any time, to revoke authorization of payment using credit card.

Signature: ____ Date: _________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Name of Client:_____________________________

I hereby acknowlege that I have received a copy of this office's Notice of Privacy Practices and completed the Clinical Policies Packet.

Signature of Parent/Guardian:_____________________________________

Print Name: ____

Date signed:_______________________

FOR OFFICE USE ONLY:

Reason HIPPA Acknowledgement Refused:

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