



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, if requested, 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 of Payment for 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 (including Oxford), 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. Insurance co-payments are also due at the time of service.

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 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. All evaluations will be sent to your child's referring pediatrician following completion of the evaluation. **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 insurance 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. It is ultimately your responsibility to know your insurance coverage insurance coverage is not a guarantee of payment.

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

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)

Please list any other health care provider of than your pediatrician (e.g. ENT, GI, neurologist, psychologist, ABA therapist, other medical providers, etc.) who are part of your child's team.



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 participate 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: _____

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.



Parental Consent and Release Form For Media Use

As the parent and/or legal guardian of the child listed below, I hereby give consent to Creative Development, LLC to use photograph(s) or other electronic media of my child (hereafter “Images”) for any business purpose, including but not limited to, use in print, publications, periodicals, books, brochures, video and/or audio productions, advertising and/or promotional materials, social media platforms, websites, Instagram, Facebook, or any other media.

By my signature below, I hereby release Creative Development, LLC and its owners, directors, managers, employees, and contractors, from any and all liability that may arise in connection with the Images. This release shall be binding upon my heirs, next of kin, executors, and administrators.

I understand that I may revoke this authorization and terminate further use of the Images at any time by providing written notification to Creative Development, LLC. I understand that my revocation will not affect any actions taken prior to Creative Development, LLC’s receipt of written notification of termination.

I am the parent or legal guardian of the child names below and have the legal authority to execute this consent and release.

Signature of Parent/Guardian

Date

Name of Parent

Relationship to Child

Name of Child

Date of Birth



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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.

We strive to schedule your child during a preferred time for you and your family however this is also based on the availability of the facility and current openings within Creative Development, LLC. In addition, your child may be scheduled with various therapists dependent on your availability when scheduling/rescheduling appointments.

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 continuity of care, we strongly recommend rescheduling cancelled appointments for maximum therapeutic care. For cancellations please call the office at 860.284.9779 or send an email to admin@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 ongoing scheduled appointments with possible discontinuation of services. This includes:

1. **Cancelling 24 hours or less will result in a \$75 cancellation fee. If there are greater than 2 cancellations less than 24 hours within a 30-day period, may result in discharge from services.**
2. **"No Show" will automatically result in a \$75 fee. After 2 "no shows" at any given time your child will be discharged from services.**

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: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red/running eyes. This also includes symptoms of various illness such as the flu, Coxsackieviruses (eg. Hand/foot/mouth virus), Children/families must be fever and symptom free for 24 hours before resuming services. MD notes are required for illnesses that last greater than 7 days.

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 you may access our website (www.creativedevelopmentct.com), on FB at "Creative Development, LLC or instagram "creativedevelopmentllc". You can also call 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/Medical Care

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 abide by these standards. **In the event of an injury or medical event at Creative Development, LLC:**

I give permission for staff to initiate first aid/CPR until advanced care arrives, if warranted.

I do not give permission for staff to complete CPR. I do agree to calling 911 or my child's pediatrician if warranted.

I give permission to have staff complete first aid only followed by communication with guardians.

other (please explain): _____

Parent/Guardian Signature

Date

PATIENT INFORMATION FORM

ALLERGY ALERT: EPI PEN Y/N

PLEASE COMPLETE ENTIRE FORM.

PATIENT: (THIS SECTION REFERS TO PATIENT ONLY)

Client's Name:							
Address:						Birth Date:	
City:		State:		Zip:		School:	
Home Phone:				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 payer 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.

Parent /Legal Guardian 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.

This consent will expire 1 year from the date of signature.

Parent/Guardian Signature: _____ Date _____



Caregiver Coordination of Care

Client Name: _____ DOB: _____

We understand that your child may have important caregivers/family members who are part of your child’s team. Please list any all caregivers/family members whom we can communicate with regarding your child’s care at Creative Development, LLC in addition to our communication with you.

Name/Contact Info: _____ Relationship to Child: _____

Name/Contact Info: _____ Relationship to Child: _____

Name/Contact Info: _____ Relationship to Child: _____

Name/Contact Info: _____ Relationship to Child: _____

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.

This consent will expire 1 year from the date of signature.

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.

Invoices/Statements:

I allow Creative Development, LLC to send statements/invoices to my email address.

I do not allow Creative Development, LLC to send statements/invoices electronically. Please mail the statements/invoices to my home address.

Please send automatic appointment reminders to my email address on a consistent basis.

Please do not send automatic appointment reminders.

Parent/Caregiver Signature

Date



AUTHORIZATION OF PAYMENT FOR 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 as it appears on Credit Card: _____

Billing Address: _____

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 the financial policies. If insurance does not cover services or payment is not received, I authorize the above practice to process the above credit card as the "Card on File".

In the event that this credit card expires or becomes invalid, I will provide an updated credit card to be kept on file and to be used for the payment of any outstanding balances owed to Creative Development, LLC. This authorization form will remain in effect until the expiration of the credit card. I understand that I can revoke this form by submitting a written request to the practice.

Signature: _____

Date: _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Name of Client: _____

I hereby acknowledge 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:
