Miss B's Butterflies
ABA, PT, OT, and ST Services, LLC
Office Number 225-323-8279| Fax 225-529-2369| Email info@missbsbutterfies.com
1200 South Acadian Thruway STE 217
Baton Rouge, Louisiana 70806

New Patient Registration Information

Welcome and thank you for choosing Miss B's Butterflies ABA, PT, OT, and ST Services, LLC. to provide services to your child, your most valuable gift. We value all of our clients and are committed to providing you with high quality evidence-based therapy services.

This packet includes all of the new patient forms that will need to be completed in order for us to assist with your care.

1. Medical History

2. Financial

3. Payment Policy

4. Insurance Signature on File

5. Patient Agreement: Medicaid, Medicare and Insurance Policies

6. Telepractice Consent and Requirements

7. Attendance Policy

8. Medical Release Form

9. HIPAA Policy

10. Media Permission

Please take a few moments prior to your appointment to review and complete the registration forms. We ask that you fax or email this packet to the following secure sites:

Fax: (225)529-2369
Email info@missbsbutterflies.com

If you have any questions, please call the practice at 225-323-8279 and we will be happy to assist you.

Sincerely,

Miss B's Butterflies ABA, PT, OT, and ST Services, LLC.

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

CASE HISTORY
Medical History (Children Ages 0-21)

Child's Name _____
First **Middle** **Last**

Date of Birth _____Age _____ Male _____Female _____

Chronological Age: _____ (OFFICE USE ONLY)

Address _____
Street Address

_____
City State Zip Code

1) Legal Guardian _____DOB _____ Age_____
Relationship to child _____ Phone Number _____
Occupation _____Highest Education Level _____
Email _____

2) Legal Guardian _____DOB _____ Age_____
Relationship to child _____ Phone Number _____
Occupation _____ Highest Education Level _____
Email _____

Child's Social Security Number: _____-_____-_____ Ethnicity _____
Who does the child reside with? _____Mother _____Father _____Both Parents_____Other
Is this child adopted? _____yes _____no Child's Race/Ethnicity _____

Who referred you to our office?_____
Pediatrician's name _____
Name of office and address: _____
City _____ State _____Zip _____

Does your child have any medications/allergies/conditions? If so, please explain

_____

_____

Medication(s)	Dosage	Frequency

Medications (Include prescription drugs, over the counter meds, vitamins, and homeopathic

Allergies/Reactions:_____

Diagnoses (Any known medical diagnosis or medical condition, with dates of diagnosis if known):

_____

EMERGENCY CONTACT:

NAME_____

PHONE_____Relationship _____

I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review patient's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ _____

Parent/Legal Guardian Signature Date

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FAMILY HISTORY
Ages 0-21

Siblings

Name	Age	Name	Age

Is there a family history of the following

Speech/Language Difficulties	Yes	No	Family Member(s)
Learning Disabilities (ex dyslexia)	Yes	No	
Hearing Impairment/Deafness	Yes	No	

Languages

Are there any languages other than English spoken in the home? _____Yes _____No

If yes, what languages? _____

Does the child speak this language? _____Yes _____No

Does the child understand this language? _____Yes _____No

Which language does the child prefer to speak at home? _____

At school? _____(if applicable)

Reason for Referral/Services

_____Evaluation _____Treatment _____Evaluation and Treatment

What concerns do you have in regards to your child's speech and language skills?

_____

_____

_____

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Birth History

Pregnancy/Delivery: Length of Pregnancy: _____ Birth Weight: _____

Birth was: Vaginal___ Cesarean ___ Breech___ Multiple Birth _____

Was your child in the Neonatal Intensive Care Unit (NICU)? Yes _____ No____ If so, for how long? _____

Why? _____

B. At Birth: Normal: Yes _____ No _____

Jaundiced: Yes _____ No _____

Cyanotic (blue): Yes: _____ No _____ Other (list) _____

Were there any feeding problems? Yes _____ No _____

Are there any feeding problems at this time? Yes _____ No _____ If yes, please explain

_____

_____

_____

Developmental History

Motor Development Milestone	**List age**
Sat unsupported	
Crawled	
Walked	
Fed Self	
Toilet Trained	
Other:	

Check if your child: ___ Falls or loses balance easily ___ Has difficulty eating ___ Has difficulty swallowing

Speech/Language Development Milestone	**List age**
Babbled	
Used first word	
Put words together	

How does your child currently communicate? For example, gestures, single words, phrases, complete sentences? _____

Speech/Language Development Milestone

How does your child's voice sound? Normal ___Too high pitched ___Too low pitched ___Hoarse ___Nasal __

Does your child repeat or block sounds or words? Yes __ No __

Do they exhibit physical behaviors related to stuttering? Yes __ No ____

Does your child have difficulty making any particular speech sounds? Yes __ No _-_ If so, which ones?_____

Do others, outside your family, have trouble understanding your child? Yes: __ No __

Does your child seem to be aware of speaking differently from others? Yes __ No __ If so, describe:_____

Does your child seem to have any difficulty understanding speech or directions? Yes __ No __ If so, describe:_____ _____

Is your child frustrated by his or her communication difficulties? Yes_____ No _____

Check any of the following that apply to your child:

Sucking problems _____ Swallowing problems _____ Feeding problems _____

Seizures _____ Attention Deficit Disorder _____ Tourette's Syndrome _____

Language Learning Disability ____Pervasive Developmental Disorder ____ Auditory Processing Disorder ___

Seizure Disorder _____ Hearing Loss _____ Frequent ear infections _____

PE Tubes _____ Hearing Aids _____ Autism _____

Cleft Lip and/or Palate _____ Pierre Robin Sequence _____ Down syndrome _____

Developmental Delays _____ Asperger Syndrome _____

Does your child have any other medical problems? Yes___ No ____

Please specify_____

_____

_____

Do you have any other concerns about your child? Yes_____ No_____ If yes, please explain

_____

_____

_____

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Release of Information

Client's Name _____ DOB _____/_____/_____

Please initial the following:

_____I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication to Miss B's Butterflies ABA, PT, OT,and ST Service, LLC.

_____ I authorize the release of information to include the diagnosis, records; evaluation rendered to me and claims information. This information may be released to:

____ Spouse _____

____ Child(ren) _____

____ Other _____

_____ Information is not to be released to anyone.

MESSAGES

Please **call** _____ my house _____ my work _____ my cell phone number

If unable to reach me:

_____ you may leave a detailed message

_____ please leave a message asking me to return your call

Parent/Legal Guardian Name (PRINT) _____

Parent/Legal Guardian Signature _____

Date _____

Witness _____

If your child has an IEP through his/her school, please bring us a copy for our records. **If your child has a neuropsych evaluation or any additional testing, please bring us a copy for our records.**

This Release of Information will remain in effect until terminated by me in writing.

HIPAA SIGNATURE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):
I acknowledged that I have viewed, read, and understand the HIPAA Policy (attached at the end of this packet) and have been informed of my rights as a patient or parent/guardian.

Print name _____
Patient/Legal Guardian

Signature _____

Signature Date _____

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Financial Policy

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Miss B's Butterflies, ABA, PT, OT, and ST Services, LLC. for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Miss B's Butterflies, ABA, PT, OT, and ST Services, LLC. you are required to carefully review and sign our payment policy.

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs. What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company. You must pay any co-payment, deductible or any amount that is not covered by your insurance at the time you receive the service.

- Should your insurance coverage change, our office should be notified within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account and all future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.

- Our fees are generally considered to fall within the acceptable range by most insurance carriers and therefore are covered up to the maximum allowance determined by each carrier. This applies to the companies who pay a percentage (such as 50% or 80%) of the usual, customary, and reasonable rate (UCR). This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. Please note insurance companies may indicate the services were not medically necessary and claim that they will not pay the balance. You will be billed for the services. This office cannot accept responsibility for negotiating settlements on disputed claims.

- You need to contact your insurance company with any questions about what they will cover. As a courtesy to our clients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 30 days from the date of service, you agree to make arrangements for prompt payment.

Financial Policy

- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at 225-663-6794 at once so we can help you with this problem. Miss B's Butterflies ABA, PT, OT, and ST Services, LLC. will help to arrange a budget plan. If there is a need, we will help you to apply for Medical Assistance or our own Hardship Program.

Any bill not paid by the date it is due will be sent to a collection agency.

IF YOU DO NOT HAVE HEALTH INSURANCE

Miss B's Butterflies ABA, PT, OT, and ST Services, LLC. will provide service at a discounted rate. All payments must be made prior to each therapy session.

Please initial the following statements:

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.

_____ I give Miss B's Butterflies ABA, PT, OT, and ST Services, LLC permission to submit bills directly to the insurance carrier. I hereby understand the above financial policy and agree to abide by it.

NOTICE TO PATIENTS WITH MEDICAID INSURANCE

Miss B's Butterflies ABA, PT, OT, and ST Services, LLC. will verify and bill medicaid for service. Please check the Louisiana Medicaid Policy regarding financial policies for members at https://ldh.la.gov/index.cfm/subhome/1.

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Insurance

Patient Name: _____Date of Birth: _____Gender: □M □F

Address: _____

City, State: _____Zip _____

Home Phone: _____ Alternate Phone: _____

Marital Status: □Single □Married □Other: _____

Work Status: □Employed □Full-Time □Student □Part-Time Student □Retired

Relationship to Subscriber: □Self □Spouse □Child □Other _____
(If different from above)

Subscriber's Name: _____
DOB: _____
Subscriber's Address: _____
City, State, Zip:_____Zip_____
Home Phone: _____

Primary Insurance Company_____
Subscriber's ID # (please include prefix if applicable) : _____
Group#:_____
Employer's Name:_____ Plan Name:_____

Secondary Insurance Company _____
Subscriber's ID # (please include prefix if applicable) : _____
Group#:_____
Employer's Name:_____ Plan Name:_____

Were you referred by another healthcare provider? If so, please provide the following information:

Referring provider's name_____

Clinic Name _____

Phone Number _____

I understand, as the patient and/or above mentioned responsibility party, that I am fully responsible for payment of all charges incurred. I authorize my insurance benefits to be paid directly to Marla Bellinger, M.S.CCC-SLP for services rendered. I understand I am financially responsible for any deductibles, non-covered services or non-authorized services. I authorize Marla Bellinger, M.S. CCC-SLP to release any information requested by my insurance company with regards to payment of benefits.

Signature:_____ Date: _____

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Payment Policy

Please read the following information carefully:

We accept the following payment methods at this time: Insurance, **Credit Cards, Debit Cards, Cash App, Zelle, and Checks** (made payable to Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC). All therapy fees (including session fees and/or co-pays, if applicable) are due: at the time of service.
We will provide you with an invoice outlining the services rendered and the amount charged.
Please read and check all boxes to acknowledge understanding and the sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Miss B's Butterflies ABA, PT, OT, and ST Services, LLC. will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a **$25** returned check fee. Charges incurred and not paid after **30** days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which Miss B's Butterflies ABA, PT, OT, and ST Services, LLC may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within **4-6** weeks after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client's who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, understand that all cancellations require **24** hours notice and that there will be a $25 charge for any cancellations made less than 24 hours. This charge is my sole responsibility and will not be covered by a third-party source.

I, _____, (client / **guardian name)** understand and have read the **payment policy** and the risks of not adhering to it.

Print Name of Client _____ Date of Birth _____

Client/Guardian/Responsible Party Printed Name _____

Client/Guardian/Responsible Party Signature _____

Relationship to Client _____

Marla Bellinger, CCC-SLP / Witness _____

Date _____

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Patient Agreement

Miss B's Butterflies ABA, PT, OT, and ST Services, LLC offers Speech-Language Pathology, Occupational Therapy, Physical Therapy, and Applied Behavior Analysis services for clients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit the patient's therapy needs. We will also work with your primary care practitioner to coordinate your care.

Following the initial assessment visit(s), we develop a specific plan of care (POC) for review and approval by your referring provider. Once the clients' referring provider signs the (POC), we can begin working with your family to improve your loved one's condition. We want to provide our patient's the highest quality of care.

We require certain information from each patient in order to begin providing care. The attached forms need to be completed in order for us to begin service. Please do your best to complete all the information. If certain information does not apply, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payor has different guidelines for allowing coverage of speech language pathology, occupational therapy, physical therapy, and/or ABA services. It is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are needed. If the patient is a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payor does not cover speech-language pathology, occupational therapy, physical therapy, and applied behavior analysis services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON COVERED SERVICE

Private insurance companies may have limits on the amount of Speech-Language Pathology, Occupational Therapy, Physical Therapy, and Applied Behavior Analysis services covered. Once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of services. Additionally, private healthcare
Insurance payors have deductibles and copayments for speech language pathology services that are the responsibility of the patient.

While this practice will not discontinue the patient's services for financial hardships, it is expected that clients pay at the time of service and/or set up payment arrangements.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our clients' parents/guardians to resolve past due accounts in all cases. If we cannot reach a patient's parent/guardian by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection. Once an account is placed with a collection , we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT

New clients approved for speech language pathology, occupational therapy, physical therapy, and/or ABA services are responsible for any and all charges not paid for by healthcare insurance payors (Medicaid, private health insurance carriers, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Miss B's Butterflies ABA, PT, OT and ST Services, LLC. for the services we provide to you, our valued customer. Following the receipt of your monthly patient statement, please contact our practice to make payment arrangements. We accept cash, personal checks, money orders, and credit cards (VISA, MasterCard, and Discover Card); we also make credit card pre-payment arrangements for anticipated monthly patient balances. We also are willing to make reasonable payment arrangements to keep your account current. Please contact our Billing Office at 225-663-6794..

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your child's caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone at 225-663-6794. A member of our management team will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our clients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Miss B's Butterflies ABA, PT, OT and ST Services, LLC. to provide me speech language pathology, occupational therapy, physical therapy, and/or applied behavior analysis services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.
Name of client _____

Parent/Legal Guardian Signature _____

Signature Date _____

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Telepractice Information and Consent

Telepractice is the delivery of therapy services using distance technology, typically computers, when the clinician and patient/client are not in the same physical location. Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC provides therapy services through telecommunication technology by linking clinician to client. We facilitate the remediation of disorders through assessment, intervention and treatment. Additionally, we equip our clients with the strategies, techniques and resources they require to achieve their goals.

Potential Benefits:

1. Allow for remote therapy services either by choice or when in-person services aren't available.
2. Provide education and support to caregivers to foster carryover.
3. Allow for greater convenience for all parties and reduction of cancellations.

Potential Risks: As with any service, there may be potential risks associated with the use of telepractice. These risks include, but may not be limited to:

1. Quality and strength of Internet connection may vary and/or may not be sufficient for high-quality video and audio to allow for effective interaction.
2. Security protocols of the Internet-based programs could fail, causing a breach of privacy of confidential clinical/medical information.

We provide speech therapy services to children ages birth to 18 years of age, using a variety of software and assessments are used to chart progress and determine which approaches work best to increase the client's skills. Treatment plans are tailored to meet your specific needs. Each client will receive direct instruction in home to effectively use strategies and techniques to generalize skills beyond the therapy context.

Surveys will be provided to determine the amount of support required to facilitate the best therapy experience as possible. Factors that will be considered include: availability of technology, ability to complete home programming, conducive environment for telepractice, and caregiver support to facilitate and operate technology and transmission. (ASHA, 2020)

Telepractice Requirements:

The patient must have access to the following components to have a successful experience.

1. Wifi and internet connection: You must have internet to be able to connect to online therapy sessions.
2. Computer, laptop, iPad or other electronic device: You must have an electronic device that has a camera in order to stream sessions. A computer or laptop is preferred.
3. Have an email address: Secure Email will be the armory mode of communication. Materials, resources and home programming will also be provided in your email.

4. Connect to my Google Meet or Zoom therapy space: You must be able to access my virtual therapy space. A link will be provided in your email that will take you straight to our zoom meeting.
5. Caregiver Present: A caregiver must be present for children or anyone who requires supervision and facilitation. This applies to clients who can not operate the computer and devices alone.
6. Must have an email address so you can have access to link to receive services.

_____ I have the basic components for online therapy as listed above.

_____ I do not have the basic components for online therapy as listed above.

Consent:
By signing this form, I understand and agree with the following:

- The laws that protect the privacy and confidentiality of health information also apply to telepractice. Information obtained during telepractice sessions will not be given to anyone without my consent.
- As with any Internet-based communication, I understand that there is a risk of security breach.
- I have the right to withhold or withdraw my consent to the use of telepractice.
- I have the right to inspect any information obtained and/or recorded through telepractice.
- I may expect the anticipated benefits from the use of telepractice, but I understand that no results can be guaranteed.
- I have the right to inspect any information obtained and/or recorded through telepractice.
- I may expect the anticipated benefits from the use of telepractice, but I understand that no results can be guaranteed.
- I have read and understand the information provided above regarding telepractice, and all of my questions have been answered to my satisfaction.
- I hereby consent to the use telepractice in the provision of speech therapy services.

_____ _____
Client's Name Date

_____ _____
Parent/Caregiver Name Date

_____ _____
Witness Date

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Attendance Policy

You are expected to attend **every session t**hat is scheduled. A 24 hour notice is required for rescheduling or canceling for an appointment. Please discuss schedule changes at the end of your appointment with your therapist. We understand occasional changes are necessary due to illness, vacations, etc. Again, please call our office within 48 no later than 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment.

No shows will be charged $25.00 for missing the session. $1 will be incurred for each minute of tardiness to a session. These fees are not covered in insurance.

_____I understand it is my responsibility to communicate with my therapist of any schedule changes or appointment cancellations.

_____ I understand that I am responsible for “No-Show” and tardiness fees

Parent/patient signature_____

Date _____

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

Discharge Criteria

It is the policy of Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC. to discharge clients who meet any of the following criteria: no longer demonstrate need for intervention; do not appear to benefit from continued services; are not meeting financial responsibilities to Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC.; do not meet the required attendance; are removed at the request of the caregiver; or are removed at the discretion of the (including for safety reasons).

. ● No Longer Demonstrates Need:

If the patient has demonstrated sufficient progress in therapy and testing reveals their skills are at age- appropriate or at functional levels (i.e., no further intervention is indicated), the therapist will review the patient's progress with the caregiver and plan a discharge date.

● Does Not Appear to Benefit:

Progress in therapy is reviewed on a continuous basis. If the patient does not meet therapy goals and/or does not demonstrate progress on re-evaluation after six months in therapy, the treating therapist will discuss the lack of progress and the treatment plan with their clinical supervisor and the patient's caregiver. They may revise the treatment plan to better fit the patient's needs at any time. If the patient does not meet therapy goals and/or does not demonstrate progress on a re-evaluation during the second six month treatment period, the treating therapist will discuss the treatment plan with their clinical supervisor and the child's caregiver. An interdisciplinary team review shall be initiated. This discussion will include the possibility of revising the treatment plan, increasing or decreasing the frequency of sessions, and discharge if no progress continues to be noted.

PHOTO PERMISSION

Please initial the following OPTIONAL statements:

_____ I give permission for photos/videos of the patient to be used for the purposes of treatment, education, and documentation.

_____ I give permission for photos/video of the patient to be used for advertising, brochure, and/or webspace.

TECHNOLOGY PERMISSION

Please initial the following OPTIONAL statements:

_____ EMAIL: I give permission to Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC to correspond with the patient, guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that Miss B's Butterflies ABA, PT, OT and ST Services, LLC. An email is encrypted internally; however once an email is sent externally, correspondence may potentially be intercepted by an outside party.

_____ TEXT: I authorize Miss B's Butterflies ABA, PT, OT and ST Services, LLC. to send text messages to my cell phone related to the patient's therapy. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC. I agree not to hold

Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC. is not liable for any electronic messaging charges or fees generated by this service. I understand that Miss B's Butterflies ABA, PT, OT and ST Services, LLC. send text messages to my cell phone that are not secure and potentially could be intercepted by an outside party.

MISS B'S BUTTERFLIES
ABA, PT, OT, and ST Services, LLC

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:
Please initial the following statements:

_____ I hereby give Miss B's Butterflies ABA, PT, OT and ST Services, LLC. Agency, LLC. permission to evaluate and treat me and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and Miss B's Butterflies ABA, PT, OT and ST Services, LLC. staff.

Patient/Legal Guardian Signature

_____

Date _____

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested

restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-677