Abbott & Burkhart Therapy

PATIENT INFORMATION

PATIENT

Legal Name: Last	First	Middle Initial	Social Security Number - -
Street Address			Birth Date
City	State	Zip Code	Are you a student? YES NO
Emergency Contact	Relationship		Phone Number
Area of Concern			

PARENT/SPOUSE

Legal Name: Last	First	Middle Initial	Social Security Number - -
Street Address			Birth Date
City	State	Zip Code	Email
Home Phone	Cell Phone		Work Phone
Employer	Employer Address		

PRIMARY CARE PHYSICIAN

Physician's Name			Specialty
Address	City	State	Zip Code
Office Phone	Fax	NPI	
Date Last Seen	Reason		

REFERRING PHYSICIAN

Physician's Name			Specialty
Address	City	State	Zip Code
Office Phone	Fax	NPI	
Date Last Seen	Reason		

PRIMARY INSURANCE

Insurance Name		Effective Date	
Subscriber Name		Birth Date	
Relationship to Patient		Social Security Number - -	
Subscriber's Employer	Policy#	Co-Pay	Deductible

SECONDARY INSURANCE

Insurance Name		Effective Date	
Subscriber Name		Birth Date	
Relationship to Patient		Social Security Number - -	
Subscriber's Employer	Policy#	Co-Pay	Deductible

ADVANCED SCREENING

Formal Hearing Evaluation **YES NO**	When	Where	Results
Formal Vision Evaluation **YES NO**	When	Where	Results
Adaptive Equipment **YES NO**	Type	Reason	
Sensory Issues **YES NO**	If **YES**, please explain		
Attention Issues **YES NO**	If **YES**, please explain		
Behavior Issues **YES NO**	If **YES**, please explain		
Feeding Issues **YES NO**	Picky Eater **YES NO**	If **YES**, explain	

CONSENT TO VIDEO

I do hereby grant and give permission to Abbott & Burkhart Therapy, to take and use video photography of my child. I understand that the video will become property of Abbott & Burkhart Therapy for educational purposes only.

_____ _____

Patient/Legal Guardian/Parent Signature Relationship to Patient

_____

Date

CONSENT TO TREATMENT

I do hereby consent to such treatment by the authorized personnel of Abbott & Burkhart Therapy as may be dictated by prudent medical practice by my illness, injury, or condition.

_____ _____

Patient/Legal Guardian/Parent Signature Relationship to Patient

_____

Date

ABBOTT & BURKHART THERAPY TREATMENT POLICIES

CANCELLATION POLICY

1. Cancellations must be made within 24 hours of the appointment time. Notification of cancellation of 6 hours or less will be considered a "No Show". If you fail to show for a scheduled appointment, or cancel with less than 6 hours notice you will be charged $25.00.
2. If ill, please call and cancel your appointment. We do not want to spread any illness between our clients. If you do not call and we deem that the client is too sick to be seen, we reserve the right to cancel the appointment.
3. In the event you are late 15 minutes or more for your scheduled appointment, call before your session begins. A "No Show" will be considered 15 minutes after the appointment start time and the therapist may leave.
4. Contact the office at 805-650-6290, or contact your therapist directly on their cell phone.

OFFICE POLICY

1. It is your responsibility to provide our office with complete and accurate insurance information at each visit. Please present your card for copying so that we may file our claims correctly. We must be informed immediately of any changes to your insurance information.
2. It is your responsibility to provide our office with a referral from your Primary Care Physician on the day of service.
3. It is your responsibility to provide our office with any address or phone number changes.
4. A $10.00 service charge will be added to all balances over 60 days past due.
5. If you have signed advanced directive it is your responsibility to provide our office with a copy for your chart.

FINANCIAL POLICY

1. Patients are responsible for payment of their accounts regardless of insurance coverage. If the patient is a minor, the parent or guardian is responsible.
2. Payment of co-payments, deductibles, and non-covered services is due at the time of service.
3. Patients are responsible for costs of collection, including reasonable attorneys' fees and collection agency costs that may be incurred in the collection of any and all indebtedness. If the patient is a minor, the parent or guardian is responsible.

THE ABOVE AFOREMENTIONED POLICIES ARE EFFECTIVE IMMEDIATELY.

I AM AWARE AND UNDERSTAND THE ABOVE POLICIES.

_____
Patient Name

_____ _____
Patient/Guardian Signature DATE

NOTICE OF PRIVACY PRACTICES

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of our patient's medical information is important to us. We understand that medical information is personal and we are committed to protecting it. We create a record of the care and services patients receive at our organization. We need this record to provide patients with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

The law requires us to keep your medical information private, give this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and follow the terms of the current notice.

We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We also have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Prior to making an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose medical information for any purpose not listed below, without specific written consent. Any specific written consent you provide may be revoked at any time by writing to us.

For Treatment: We may use medical information to provide treatment or services. We may disclose medical information to doctors, educators, service coordinators, or other providers consented by you.

For Payment: We may use and disclose medical information for payment purposes. A bill may be sent to the patient or third party payer. The information on or accompanying the bill may include your medical information.

Additional Uses and Disclosures: In addition to using and disclosing medical information for treatment and payment, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your location or general condition. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for a patient's health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use or disclose medical information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

YOUR RIGHTS

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photos copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or different locations. Your request that we communicate your medical information by different means or location must be made in writing to our Business Administrator.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request to our Business Administrator.

If you have any questions about this notice, please speak to our Business Administrator.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and fully understand Abbott & Burkhart Therapy's Notice of Privacy Practices. I understand that Abbott & Burkhart Therapy may use or disclose my personal medical information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal medical information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Abbott & Burkhart Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Abbott & Burkhart Therapy's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

If patient is not capable of acknowledging the notice because of age or medical condition, please complete the following:

Patient is a minor (_____ years of age) OR patient is unable to acknowledge because

_____

_____ _____

Patient Name Patient/Guardian Signature

_____

Date

****OFFICE USE ONLY****

Version Given: _____

Name of Client: _____

CONSENT TO OBTAIN / RELEASE MEDICAL INFORMATION:

☐ I hereby authorize **Abbott & Burkhart Therapy** to file a claim to my insurance company for services rendered. I further authorize **Abbott & Burkhart Therapy** to release all necessary information to my insurance company, third party payer, or its agents for determination of benefits and completion of insurance claims.

☐ I consent to and authorize **Abbott & Burkhart Therapy** to release any medical and educational records to the following individuals listed below who have provided or are providing medical or educational services to the above named client.

HIPAA

I understand that these records will be used only to coordinate medical and educational services to the above named client and that **Abbott & Burkhart Therapy** protects the confidentiality of client information and releases information only according to the policies based on federal and state law and HIPAA standards. Only persons responsible to the direct care of the above named person are privy to information regarding the above named person.

Name of Primary Physician	**Address/City/Zip**	**Phone Number**
Name of Other Medical Providers	**Address/City/Zip**	**Phone Number**
School District/Educational Agency	**Address/City/Zip**	**Phone Number**
Tri-Counties Service Coordinator	**Address/City/Zip**	**Phone Number**
Other Agencies	**Address/City/Zip**	**Phone Number**

I understand that Consent to release information is valid until the above named client turns 21 years of age. All or part of the consent to release information can be canceled or changed upon receipt of written notifications for the undersigned.

Parent/Guardian Signature: _____ Date: _____

Relationship: _____

Name of Client: _____

CONSENT TO VIDEO

I, _____, hereby grant and give permission to Abbott & Burkhart Therapy, to take and use video photography of my child. I understand that the video will become property of Abbott & Burkhart Therapy for educational purposes.

I HAVE READ THE ABOVE AUTHORIZATION, RELEASE, AND AGREEMENT, BEFORE ITS EXECUTION, AND AM FULLY AWARE OF THE CONTENTS THEREIN.

Date: _____, 201___

_____ _____

Patient/Guardian Signature Print Name

Abbott & Burkhart Therapy
1601 Eastman Avenue, Suite 103
Ventura, CA 93003
Phone: 805-650-6290
Fax: 805-650-6912

Thank you for choosing Abbott & Burkhart Therapy as your therapy provider. Please place an "X" indicating your availability.

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00am					
9:00am					
10:00am					
11:00am					
12:00pm					
1: 00pm					
2: 00pm					
3: 00pm					
4: 00pm					
5: 00pm					

Child's Name: _____ **Date:** _____

Guardian's Name: _____