Building Kid Steps Pediatric Services
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

Personal Information Sheet

Date (Fecha): _____ Person Completing Form (persona completar formulario): _____

Child's Name: _____ DOB: _____ Age: _____

Gender: ___ Male ____ Female Grade: _____ Social Security Number: _____

Address: _____

Primary Phone: _____ circle the one Home Cell Work Other: _____

Best Way to contact you in case of an emergency: Home phone Cell phone Work phone Text Email:_____

Do You wish to receive reminders about therapy appoints: ☐Yes ☐No

If yes how: ☐ text _____(phone number) ☐email: _____ (email address)

Contact in Case of Emergency: Provide 2

Name: _____ Phone Number: _____ Relationship to Child: _____

Name: _____ Phone Number: _____ Relationship to Child: _____

List all persons who can bring child to therapy and participate in therapy discussions on therapy day should the need arise
(ANY CHANGES TO THE LIST MUST BE MADE IN PERSON AND INITIALED AND DATED)

_____
_____
_____

Parent #1 Name: _____ Parent # 2 Name: _____
Address: _____ Address: _____

City/State/Zip Code: _____ City/State/Zip Code: _____

Parent # 1 DOB: _____ Parent # 2 DOB: _____

Parent #1 Home Phone: _____ Parent # 2 Home Phone: _____

Parent #1 Cell: _____ Parent #2 Cell: _____

Parent #1 Work #: _____ Parent #2 Work #: _____

Parent #1 Email: _____ Parent #2 Email: _____

Parent #1 Employer: _____ Parent #2 Employer:_____

Child's Name: _____ DOB: _____

Building Kid Steps

117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

Insurance Information/Payment Method

☐**Self Pay** ☐**Primary Insurance:**

Name of Insured: _____ Relationship to Child: _____

Insured DOB: _____ Insured SS#_____

Insurance Co./Medicaid: _____Phone Number:_____

ID #/ Medicaid #: _____ Group Number: _____

☐**Secondary Insurance:**

Name of Insured: _____ Relationship to Child: _____

Insurance Company: _____ID#/Medicaid # _____

Best Treatment Times

We strive to accommodate your personal schedules to the best of our abilities. Please note below the best times for your child to attend therapy should they qualify. No guarantees will be made about accommodating your schedule but every attempt will be made to do so.

Which therapies will your child be receiving? ☐ Speech (ST) ☐Occupational (OT) ☐Physical (PT)

How many days a week do you feel you could attend therapy? ☐1 ☐2 ☐3

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
1:00 pm					
2: 00 pm					
3:00 pm					
4:00 pm					

Please mark the areas with the numbers 1 through 3 for your first, second, and then third choice of times.

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Consent for Evaluation and Treatment

I give my permission for _____ (child's name) to participate in a (please initial before each section of the evaluation that your child may be participating in)

____ Speech Evaluation on _____ (date) ____ Physical Evaluation on _____ (date)

____ Occupational Evaluation on _____ (date)

I give my permission should my child qualify for therapy to participate in treatment for

_____ Speech Therapy _____ Physical Therapy _____ Occupational Therapy

_____ (signature of parent/guardian)

I. Identifying Information

Language at Home (lenguaje en casa): _____Other Language (otro lenguaje):_____

Referring Physician:_____ Primary Physician:_____

Who does the child reside with (siblings, parents, grandparents, etc)?
(Con quien vive el nino/nina (hermanas, padres, buelitos, etc.)

_____

Who cares for the child during the day? (daycare, school, parent, etc.)?
Quien cuida el nino/nina durante el dia (escuela, padre, etc.?

_____

II. Statement of Problem

What concerns do you have in regard to your child's speech/language, physical, feeding, or developmental abilities? (Que preocupacion/s tiene usted de las habiliades del habla/lenguaje/communicacion, fisica, alimentamiento, o cresimiento de su hijo/hija?)

_____
_____
_____

When was/were the problem(s) first noted? Any changes since? (Desde Cuando noto el problema(s) (ha sido cambios)?)

_____
_____
_____

Family history of speech/language/hearing, physical, feeding, or developmental problems? Yes:____ No: ____
(Hay historia familiar de problemas en habla/lenguaje/communicacion, fisica, alimentamiento, o cresimento?)
Comments:_____

_____

Child's Name: _____ DOB: _____

Building Kid Steps

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Has your child received (Ha recibido servicios de un terapista de habla/lenuaje antes, terapista de fiscia, terapista de ocupacional)

Speech Therapy: ___ No ___ Yes – When:_____ Where:_____ How long:_____

Physical Therapy: ___ No ___ Yes – When: _____ Where: _____ How long: _____

Occupational Therapy: ___ No ___ Yes – When: _____ Where: _____ How long: _____

III. Educational Information/Behavior

If school age, what school/grade is your child in? (Si edad de escuela que grado/esuela esta?)

_____

Special Educational Services (self-contained, resource, speech, etc.) receiving in school? (Recibe clases especiales? (terepia, resource, etc))

_____

How is your child doing academically in school (reading, writing, etc.)? Como esta hacienda en sus clases (leyendo, escribiendo)?

_____

_____

Describe child's interactions with other children/adults (Describir el comportamiento con otros ninos/ adultos (bien, agrgressivo, peleya, etc))?

_____

_____

IV. Prenatal/Birth History

Length of Pregnancy/embarazo: _____ Length of labor/parto: _____ Was child in NICU? ___ No ___ Yes ___ how long

Length of hospital stay/complications: _____

_____

Birth Weight: _____ Oxygen Required: _____No _____Yes Comments:_____

Type of Delivery: Natural C-section Comments: _____

Labor Induced: ____ No _____ Yes Comments: _____

Breech: ___ No ____ Yes Comments: _____

Mother's general health during pregnancy (complications, accidents, illnesses meds) (Describir su salud duranted su embarazo (acciendentes, medicinas, enfermedades, etc) _____

_____

_____

V. Medical History

Child's Name: _____ DOB: _____

Building Kid Steps

117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

List any diagnoses that have been given to your child and by whom: _____ My child has no formal diagnosis.

Diagnosis	Who Gave
_____	_____
_____	_____
_____	_____

Has your child had any surgeries or accidents? ___ No ____Yes (Please list when and what) _____

_____

_____

Please list all medications your child is currently taking including over the counter medications: ___ No Medications

Drug Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please List all doctors your child is currently seeing:

Physcian's Name	Phone Number	Town
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Please check all allergies that your child has

- ☐ **Food** _____
- ☐ **Non-food** _____
- ☐ **Latex** _____
- ☐ **Medications** _____

Has your child had ear infections (infections de oidos?) _____ No _____ Yes If yes, how many in the last year? _____

Does your child have PE tubes? ____ No _____ Yes If yes, when: _____

Has your child's hearing been checked (ha recibio un ezmin de oidos)? _____ No ____ Yes If yes, when _____

Child's Name: _____ DOB: _____

Building Kid Steps

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Where: _____ Results: _____

Does your child have any vision problems (esta problemas de la vista) ____ No _____ Yes If yes, describe: _____

_____

Has your child seen an ophthalmologist? ____ No ____ Yes If yes, When: _____

Where: _____ Results: _____

Are there any medical precautions the therapist should be aware of when working with your child? _____

_____

_____

Does your child currently have any assistive devices (eg: glasses, casts, wheel chair, speech generating device)? _____

_____

_____

What concerns you the most about your child?

Are there problems with any daily routines?

Please tell us about your child's strengths and gifts.

What particular skills would you like your child to achieve in the next six months?

How, if in any way, would you like to interact differently with your child?

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Rules and Policies

These are our clinic policies and are very important. Please read, return.

Child's Name: _____ Date: _____

Please check or initial each box.

☐Absences or Missed therapy sessions:

Each participant is allowed 2 cancellations in the fall (September through December) 2 cancellations in the spring (January through May) and 2 cancellations in the summer (June through August). A cancellation may be due to illness and/or schedule conflict. It is considered a cancellation when you call within 12 hours of your scheduled appointment otherwise it is marked as a no show. After the 2 cancellations per season your insurance and /or doctor's office will be notified of each cancellation. If you do not return within 30 days you will be discharged. If you have more than 3 cancellations per season then a meeting with the director will be set up to determine why attendance to therapy is poor. More than 5 cancellations can result in dismissal from therapy.

Our current hours of operation are Monday through Friday 8 am to 5 pm with a lunch taken from 12 pm to 1 pm. We observe the following holidays: New Years Day, ½ Day on Good Friday, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day. We are open for therapy all other days. As those holidays approach, you will be asked to make arrangements to reschedule if you are missing therapy due to a holiday.

☐No show Policy

Each participant will be allowed 3 No shows for the entire year (date of entry to following year to date). The definition of a no show is not calling for any reason to cancel your child's therapy within 12 hours of your child's scheduled appointment. If an emergency arises with less than 12 hours before your child's appointment please notify us as to the reason for the cancellation and the director will be notified of your cancellation. If we call you because you didn't show for your appointment it is a no-show. Your doctor and/or insurance will be notified of non-compliance to therapy attendance. After 3 no shows you will be dismissed from therapy due to non-compliance. We do not count no shows consecutively it is a total per year.

☐Vacations, Summers, and 30 day holds

If you are planning to go on vacation for a length of time and/or if you need to place your child's therapy on hold for up to 30 days then you will need to see the director to make arrangements. Only one 30 day hold per child will be allowed without a medical reason and a doctor's note. If you plan to take a summer break or stop therapy for any length of time past 30 days you need to let the staff know two weeks in advance to give sufficient time to dismiss the child from therapy. You will be responsible for a new evaluation if your child has not gone more than 6 months without therapy and we will not bill your insurance or Medicaid for this evaluation.

☐30 day re-evaluations

We are required to assess your child every 30 days and make goal updates if necessary. These are done every 30 days from the date of the original evaluation. If you are coming to therapy one time per month, then it is your duty to get your child to therapy on or before the next 30 days. We cannot write 30 days less than 3 weeks apart. If your child goes more than 1 week past his or her 30 days you will be discharged from therapy. To return to therapy you will need to pay for a new evaluation. The staff at Building Kid Steps Pediatric Services do not consider one time per month therapy an effective way to provide therapy, therefore if you go more than 2 months with therapy only being received one time per month and it is not a result of insurance authorization or a medical reason, you will be discharged from therapy.

Child's Name: _____ DOB: _____

Building Kid Steps

117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

☐Switching Appointment Times Same Day

If you are unable to keep your appointment and call to change the time of your child's appointment time for the same day of the appointment we will accommodate you if there is a slot available with any therapist that is available. Otherwise, if you cancel, it will be considered a no show and notifications will be made.

☐Set Schedule Policy

We encourage our parents to arrange their child's therapy on a set schedule to encourage continuity of services. In addition, it allows for you to know who will be providing your child's services. If you don't have a set schedule then you will be considered a floater and will be schedule with a therapist who has a slot available. If you choose to have a set schedule (a set day and time each week that your child attends therapy) then you must consistently attend therapy on those days. This is because you are holding a slot for 3 to 6 months and it is not a slot that we will offer to any other child. If you call and reschedule or no show a set appointment time more than 3 times a season (see absences or missed therapy sessions policy) then you will no longer have that slot available to you. You will become a floater. A floater schedules on a weekly basis for therapy and they do not have any choice as to who will see their child. Whether you are a floater or are on a set schedule and cancel a regular appointment the schedule/reschedule will be made with the next available therapist or therapy assistant. If you wait for a specific therapist and don't schedule weekly when you are on a weekly schedule then each week you miss therapy will be considered a no show and after three misses you will be dismissed for noncompliance.

☐Late Arrival Policy

If you arrive more than 10 minutes late to an appointment, your appointment will be cancelled and you will be marked as a no show. At 10 minutes, the therapist reserves the right to take another patient in your spot if you have not called to say that you are on your way. At 15 minutes, the therapist reserves the right to cancel your appointment. All decisions will be left to the discretion of the treating therapist.

☐Illness Policy

In order to maintain the health of other children and our staff, please DO NOT BRING your child if they have had a fever, have had diarrhea and/or vomiting or have experienced symptoms that are considered contagious within a 24-hour period. If your child shows visible signs of illness, their appointment may be rescheduled at the therapist's discretion. If your child has a non-contagious illness such as an ear infection, allergies or sinus infection we encourage you to have your child attend therapy.

☐Personal Information Change Policy

It is the patient's/guardian's responsibility to inform BKS of any and all changes in insurance information, phone numbers, addresses, and change in physician AS SOON AS YOU BECOME AWARE THAT A CHANGE HAS BEEN MADE. FAILURE TO DO SO COULD RESULT IN TOTAL PATIENT RESPONSIBILITY FOR CHARGES INCURRED.

Child's Name: _____ DOB: _____

Building Kid Steps
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

☐Insurance and Self-Pay Policy

We attempt to verify your insurance information prior to your initial evaluation to provide you with accurate information about the charges you will receive for evaluations and treatments at BKS. Not all insurances pay for evaluations or treatments for speech, occupational, and physical therapy. You are responsible on the day of service for the charges rendered whether in its entirety while meeting your deductible, are required to pay a Co-Pay or you owe a percentage of the total charges based upon the information your insurance company provided us. The information we provide you with is an ESTIMATE of what we believe your portion to be based upon the information the insurance company has provided us. Until we have an explanation of benefits from your insurance company we cannot provide you an exact out of pocket cost. If we bill your insurance company and they don't cover all or a portion of the charges you are then responsible for the remainder of the charge. If your insurance company does not cover this type of therapy you can elect to become a self-pay patient. You will receive a 30% discount off the total charge for electing to be a self-pay customer. We will not under any circumstances bill your insurance company if you are a self-pay patient. We will be happy to provide you with documentation about the services you received to file with the insurance company on your own upon your request. It is your responsibility to inform us of how you want us to bill your charges.

☐Sibling and Waiting Room Policy

If you are bringing a sibling to the clinic, you need to bring books or small toys for them to play with while their sibling is in therapy. We expect that your children maintain a reasonable level of calm (quietly waiting, sitting appropriately) and quiet during their time waiting. If they need to walk around or are too loud we ask that you take them out in the breeze way so that we will be able to find you in the event you are needed. You may not leave the premises for any reason, no exceptions will be made and the policy for cancelling will be enforced. If you bring siblings we ask that you watch them in the waiting room while your other child receives therapy. We cannot give out toys, snacks, colors or books to siblings who are waiting. Those items are reserved for therapy. Siblings are not allowed in the therapy room. This is individual therapy for the child who qualified and it is often disruptive to the therapy process. Should you need to meet with the therapist privately and you have several individuals with you accommodations can be made. Ensuring that you children are following the waiting room expectations helps to create a comfortable environment for all.

☐ Photographs and Video Policy

I authorize, BKS to use my child's photograph and/or videotape for advertisements, educational materials and/or other display materials.

☐Licensed Assistants

Our clinic employs licensed assistants to provide therapy to children. Each licensed assistant has a taken background classes and received a college degree in his/her respective fields. Each licensed assistant is supervised by a licensed therapist. The assistants are made aware of your child's plan of care and how the therapist wants that plan of care provided. In addition, the licensed therapist will see your child a minimum of one time per month to complete monthly goal up dates. It is likely that your child will be seen by licensed assistant while receiving therapy at our clinic. We hold your child's quality of therapy paramount, and we hire highly qualified staff. Should you have any questions please ask to speak with your child's therapist or the therapy director. Only a licensed therapist can evaluate children, so after being evaluated you will be scheduled with one of the available licensed therapist or

Building Kid Steps
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

therapy assistants for therapy based on availability of scheduling and permanent slots being available. Once again, a licensed therapist will see your child a minimum of 1 time per month and your child's plan of care will be discussed with the treating therapist assistant if necessary.

In addition, we also believe in teaching others in our field, and allow students who are going to school to observe our clients in the clinic. These students are not allowed to treat your child as they are here to learn. We will inform you if any students will be observing your child during a therapy session.

☐No Leave Policy

Due to safety concerns, parents/guardians are NOT ALLOWED TO LEAVE THE PREMISES FOR ANY REASON during the treatment of your child.

☐Smoking, Drug, and Gun Policy and Child Abuse Policy

Under no circumstances are drugs, alcohol, smoking, and/or weapons allowed on the premises. In addition, if the staff at Building Kid Steps suspects any signs of child the abuse the therapist is required by law to report any signs of suspected child abuse.

☐ Private Consultations

At the end of therapy we discuss how your child's progress with you. These conversations will only last a few minutes due to scheduling of other patients, and are to only discuss the therapy that has just occurred. Should you wish to have a lengthier discussion about your child's therapy or progress, we would be happy to do so but you will need to schedule this with Liz. She will let you know when the therapist would be available to have a phone or private conference and schedule that for you.

☐ Requesting Records

You are allowed one copy of your child's records per calendar year. If your doctor, school or insurance is requesting records please have them send us signed consent and we will forward this on to them in a timely manner. If you need more than one copy of your child's records a fee will be assessed at the following rate: Medical and or Billing Records (after 1st copy): First 25 pages are $25.00 and each additional page after the first 25 is $.50 per page. Affidavit fee is at $15.00 if requested.

☐ Discrimination and Age Policy:

Building Kid Steps, LLC does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment, or on the basis of sex in its health programs and activities. For further information about this policy, contact: Amanda Luddeke, 504 Coordinator. This facility **does have** the following age restrictions for Physical and Occupational Therapy: This facility is a pediatric treatment facilityonly for these two disciplines. We treat patients from the birth to age 21 primarily for habilitation services only. Our facility is not equipped for the treatment of sports injuries or extensive re-habilitation services. If we feel that we cannot provide you or your child adequate treatment services due to our equipment, staffing or expertise we will inform you and make every effort possible to refer you to an entity that can provide you the appropriate treatment.

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Building Kid Steps
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

PATIENT NAME:_____

Rules and Policies Acknowledgement

☐I have read all of the above policies and understand them as they are written.

HIPPA

☐ **I acknowledge that I have received and understand and agree to the Notice of HIPPA** - By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Method of Disclosure and Sharing of Protected Health Information (PHI) Form

Please indicate below the method that you would like us to discuss and disclose your child's PHI to you:

☐ **In Private -** I would like to be called to an office in the back to discuss my child's PHI at the end of each visit.

☐ **In Public -** I consent to the therapist discussing my child's PHI at the end of each visit in the waiting room knowing that this information might be overheard by anyone.

I understand that Gulf Coast Rehabilitation, P.C./Building Kid Steps, LLC is not required by law to accept my requested restrictions, but if the practice does, Gulf Coast Rehabilitation, P.C./Building Kid Steps, LLC agrees to abide by the restrictions except in emergency situations.

I understand that either I or Gulf Coast Rehabilitation, P.C./Building Kid Steps, LLC may terminate this restriction in writing at any time in the future.

Signing the form agrees to all of the above information:

Signature: _____ Date: _____

Print Name: _____

or, ON BEHALF OF PATIENT

Signature: _____ Date: _____

Print Name: _____

Child's Name: _____ DOB: _____

Building Kid Steps
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY
Effective September 1, 2013

The following is the privacy policy ("Privacy Policy") of Gulf Coast Rehabilitation, P.C. ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Building Kid Steps
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:
(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal health information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

Building Kid Steps
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Third Party Disclosures

After your personal health information is disclosed to a third party it is subject to re-disclosure by the recipient and they may not be a covered entity under HIPAA.

Miscellaneous Activities, Notice

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. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Building Kid Steps
117 Medical Drive, Suite 4*Victoria, TX 77904*Phone: 361-578-2257 or Fax: 361-578-2260

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

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Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Michelle Hochdorf-Privacy Officer - P.O. Box 3666, Victoria, Texas 77903 and/or to Amanda Luddeke-Privacy Officer BKS – 8806 N. Navarro Ste. 600#120, Victoria Texas 77904.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Michelle Hochdorf-Privacy Officer - P.O. Box 3666, Victoria, Texas 77903 and/or to Amanda Luddeke-Privacy Officer BKS – 8806 N. Navarro Ste. 600#120, Victoria Texas 77904.

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Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Michelle Hochdorf-Privacy Officer - P.O. Box 3666, Victoria, Texas 77903 and/or to Amanda Luddeke-Privacy Officer BKS – 8806 N. Navarro Ste. 600#120, Victoria Texas 77904, 361-275-0532 and 361-578-2257.
A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Michelle Hochdorf-Privacy Officer - P.O. Box 3666, Victoria, Texas 77903 and/or to Amanda Luddeke-Privacy Officer BKS – 8806 N. Navarro Ste. 600#120, Victoria Texas 77904.
For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer Michelle Hochdorf-Privacy Officer - P.O. Box 3666, Victoria, Texas 77903 and/or to Amanda Luddeke-Privacy Officer BKS – 8806 N. Navarro Ste. 600#120, Victoria Texas 77904.

Child's Name: _____ DOB: _____

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HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION however, Gulf Coast Rehabilitation, P.C., ("Covered Entity") may decline to provide treatment to me if I do not sign this consent or later revoke this consent.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services and to conduct other related health care operations otherwise permitted or required by law.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to coordinate care within the covered entity and with others involved in your care, such as your attending physician and other health care professionals who have agreed to assist the Covered Entity in coordination of my care. The Covered Entity also may disclose your health care information to individuals outside of the covered entity involved in your care including family members, pharmacist, suppliers of medical equipment or other health care professionals.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to Michelle Hochdorf-Privacy Officer - P.O. Box 3666, Victoria, Texas 77903.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke or limit this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.