



HORIZON PEDIATRIC THERAPY

PHYSICAL • SPEECH • OCCUPATIONAL

Dedicated to bringing a brighter future to your child!

Welcome to Horizon Pediatric Therapy!

We are pleased to be able to meet your child's therapy needs by providing:

- Your therapist(s) will call you to confirm your first appointment day, time and location.
- Please be aware we have a clinic in Peoria and in Mesa. A majority of our operations are conducted out of our Mesa location. Intake documents should be forwarded to our Mesa office.
- Each therapy session is 50 minutes in length and you will be asked to sign a form at each visit.
- Your therapist will be providing you with home program recommendations and encourage you to incorporate specific activities into your daily routine to enable your child to achieve therapy goals. You can also expect progress reports every three months.
- Your therapist will be reviewing our cancellation policy at your first appointment. Please review this information carefully as it can impact continued services.
- If you have any questions regarding insurance or DDD, please call the office and speak to someone in our billing department.
- If you should need an additional therapy service (OT, PT, ST, or MT) for your own child, please call our office and ask to speak to the Referral Coordinator.
- If you would like to be notified by email of our openings and other news please provide us with your email address.
- Horizon is committed to hiring quality, dedicated therapists. We welcome any feedback you would like to give regarding your therapist. Please contact our office with any questions or concerns.
- Please complete the enclosed documents and fax, email or mail them back as soon as possible. We are eager to begin providing services for your child. As you may already be aware, we must get authorization from DDD before beginning services. You can always call your support coordinator to try to expedite the process.

Horizon Pediatric Therapy is Dedicated to Bringing a Brighter Future to your Child!

Sincerely,

*Lisa and Ross Fasano
Owners*

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you as a patient of Horizon Pediatric Therapy may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Horizon Pediatric Therapy is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We are also required by law to provide you with this notice of our legal duties and the privacy we maintain in our practice concerning your health information. We realize these laws are complicated, but we must provide the following important information to you. We also reserve the right to amend or revise this Notice of Privacy Practices as necessary.

Your rights regarding your health information

The health and billing records we maintain are the physical property of Horizon Pediatric Therapy. However, the information in these records belongs to you. You have the right to:

1. Request a restriction on certain disclosures and uses of your health information in writing to our office. We are not required to grant the request but we will comply with any request granted;
2. Request that you be allowed to inspect and copy your health record and billing record – you may exercise this request by delivering the request in writing to the office;
3. Appeal a denial of access to your protected health information except in certain circumstances;
4. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
5. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
6. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
7. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and
8. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you would like to exercise any of the above rights, please contact Ross Fasano, owner of Horizon Pediatric Therapy in person or in writing. We will assist you in the steps you should take to exercise your rights.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities that are authorized by law to collect information
2. To health oversight agencies for activities authorized by law. These may include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions: civil administrative and criminal procedures or actions, or other monitoring programs of the government.
3. Lawsuits and similar proceedings in response to a court or administrative order;
4. If required to do so by a law enforcement official;
5. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat;
6. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities;
7. To federal officials for intelligence and national security activities authorized by law;
8. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official; and
9. For Workers' Compensation and similar programs.

Other disclosures and uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person’s involvement in your care or in payment for such care if you do not object or in an emergency. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give a copy of this Notice to you at any time.

Right to file a complaint

If you believe your privacy rights have been violated, you may file a complaint with Horizon Pediatric Therapy or with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this Notice of Privacy Practices, please contact:

Horizon Pediatric Therapy
Attn: Ross Fasano, Owner
551 S. Higley Road
Mesa, AZ 85206
Phone 480-892-9777
Fax 480-635-0222

I hereby acknowledge that I have been presented with a copy of Horizon Pediatric Therapy’s Notice of Privacy Practices.

Signature

Printed Name of Patient

Date

Please return this signed form to:

Horizon Pediatric Therapy
551 S. Hilgey Road
Mesa, AZ 86206
Phone: (480) 892-9777
Fax: (480) 635-0222

Child Profile for _____ **Date of Birth** ___ / ___ / ___ **Age** _____

Completed by _____

Lives with Parents/Caregivers (names) _____

Phone #'s (home) _____ (work) _____ (cell) _____

Availability (check those that are appropriate)

attends school M T W Th F hours (pick up > drop off) _____

other therapy appts? (indicate day/time for each)

PT _____ OT _____ SLP _____ EI _____ MT _____ BT _____ Hab _____

naps? N/A typical times _____

daycare/ N/A typical times _____

sibling's activities that may interfere with time availability _____

parent's work schedule _____

best times for therapy AM _____ PM _____ mealtime _____ other? _____

Pediatrician name _____ **phone #** _____ **fax** _____

Specialists (type, name, phone number) _____

Reason for referral _____

Diagnosis/Concerns _____

Family living situation _____

Medication (include meds that relate to ADHD, sleeping, reflux, behavior and others) _____

Allergies – Food or Medicine? None specify _____

Diet restrictions? None GFCF no dairy other _____

Any medical concerns or movement restrictions? None specify _____

Additional team member information (*Please note that by identifying information below regarding names and phone numbers of team members, you are giving permission for Horizon therapists to contact these individuals regarding your child's therapy and/or school program)

PT name _____ phone _____

OT name _____ phone _____

ST name _____ phone _____

School name _____ District _____

Teacher name _____ phone _____

School therapists names _____ phone _____

Best motivated by stickers food praise chart coins outing other _____

Foods Likes _____ **Dislikes** _____

Favorite movies/TV shows _____

Favorite characters _____

Individual preferences/unique characteristics _____

DEVELOPMENTAL HISTORY

Background information **Child's Name** _____

full term pregnancy premature birth - # of weeks _____ Birth weight ____ lbs ____ ozs

uncomplicated pregnancy vaginal delivery c-section

Complicated Pregnancy/Delivery _____

Length of hospital stay _____ Difficulties breathing after birth? Yes/No _____

Any difficulties first two weeks of life? _____

Surgeries/Hospitalizations _____

Has your child ever had seizures? Yes / No Type of seizures _____

Hearing status WNL Not tested impaired screening BAER test full audio eval aids

Chronic URI's (upper respiratory infections) No Yes please detail _____

Hx of recurrent ear infections No Yes please detail _____

PE tubes Past Present _____

Vision Status WNL Not tested impaired screening vision therapy full vision eval glasses

Feeding/Swallowing Status nursing using bottle cup sippy reg utensils

Issues with texture? No Yes difficulty with crunchy pudding like

Previous swallow studies? No Yes Risk of aspiration? No Yes _____

Hx of intubation? No Yes please detail _____

G-tube history? No Yes please detail _____

Scarring of esophageal lining? No Yes please detail _____

Reflux issues? No Yes please detail _____

Supplements? No Yes please detail _____

Communication Status points/gestures signs verbal PECS aug com device

Description _____

At what age did your child Roll _____ Sit independently _____ Crawl _____

Walk independently _____ Babble _____ Say first words _____ Talk in phrases _____

Feed self _____ Dress self _____ Toilet self _____

Adaptive Equipment used _____

My child sleeps from _____ to _____ Naps from _____ to _____

How do you discipline your child _____

Does your child have history of aggression Yes / No _____

Tantrums? Yes / No _____

Additional Info _____

Insurance Information

Patient Name		Birth date	DDD Assist # (If applicable)	Sex	SS#
Address		City		State	Zip code
Home Phone	Diagnoses				
Father		Work Phone	Mother		Work Phone
Referred by (Physician name or DDD Case Manager)				DDD Case Manager	
Primary Physician					Phone
Private Insurance Plan (if applicable)			Employer		
Policy Holder			SS#	Birth date	
Address (if different from patient)			City	State	Zip code
Group #			ID or Policy #		
Send Claims to:					Phone
Address			City	State	Zip code
State Coverage (AHCCCS plans)			Employer		
Policy Holder			SS#	Birth date	
Group #			ID or Policy #		
Send Claims to:					Phone
Address			City	State	Zip code

MEDICAL INFORMATION RELEASE

I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies or other health care agencies. I also authorize the release of medical records or copies of such and request that they be transferred to Horizon Pediatric Therapy, Inc. 551 S. Higley Road, Mesa, AZ 85206.

FINANCIAL POLICY

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance. **Patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges.**

CANCELLATION POLICY

If you need to cancel an appointment, we request a 24-hour notice. If you cancel within less than 24 hours of your scheduled appointment, you may be charged for ½ of the scheduled session. If you do not call to cancel and fail to keep your appointment, you will be charged for ½ of the scheduled session. **Insurance will not pay for such "no shows" or late cancellation charges—these charges must be paid by the patient.** If you have 2 or more cancellations within a 4-week period, or 2 or more no shows, we reserve the right to discontinue services.

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to Horizon Pediatric Therapy.

Signature _____

Date _____

