1900 Graybar Lane - Nashville, TN 37215
(phone) 615-690-3091 (fax) 615-292-4941

Therapy Enrollment Form

Client Information

Child's Full Name ______________________________ Date of Birth ____________________

Gender: Male Female Social Security Number: ________-_______-________

Ethnicity: White/Caucasian Black/African American Hispanic American Indian
Alaskan Native Asian/Pacific Islander Other (Use Mother's ethnicity)

Address ______________________________ City/State/Zip ____________________

Client's School (if applicable) ______________________________ Grade (if applicable) ________

Parent/Guardian Names ______________________________

Home Phone ____________________ Email Address ______________________________

Address (if different from above) ______________________________

Parent One Cell Phone ____________________ Parent One Work Phone ____________________

Parent Two Cell Phone ____________________ Parent Two Work Phone ____________________

Employer of Insured ______________________________

Emergency Contact Information (must be different from parent information)

Name ______________________________ Phone Number ____________________

Relationship to Child ____________________

How did you hear about us? Friend Pediatrician Website Other ____________________

If you were referred by a pediatrician or other professional agency, please note that contact information below:

______________________________ ______________________________
Contact Name Phone Number

______________________________ ______________________________
Parent/Guardian's Signature **Date**

3/2016

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Emergency Information

Child's Name ___________________________

Medical Information
Allergies (food, medications, other) ___________________________

Current Daily Medications ___________________________

Seizures (type, typical length, special instructions) ___________________________
____
____

Hearing and/or Vision concerns or diagnosis ___________________________
____
____

Diagnosis (if applicable) ___________________________

Special considerations related to diagnosis or any other special instructions for your child ______________
____
____

Pediatrician Information
Physician's Name ______________ Practice/Medical Facility Name ______________

Phone Number ______________ Address ______________

Insurance Information
Primary Insurance Carrier ______________ ID# ______________
Phone # ______________ Effective Date ______________

Secondary Insurance Carrier ______________ ID# ______________
Phone # ______________ Effective Date ______________

Do you have a Health Reimbursement Account (HRA), Health Savings Account (HSA), or a Health Incentive Program? _______ If yes, please specify ______________

If necessary, I authorize the staff of First Steps, Inc. to sign for emergency medical treatment in the event of illness or injury during the process of receiving therapy to be given at ______________ hospital or nearest medical facility. I authorize First Steps to secure and retain transportation, and to release client records upon request to authorized emergency personnel.

Parent/Guardian Signature ______________ **Date** ______________

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Consent for Treatment

I do hereby consent for treatment by First Steps, Inc. I consent to the evaluation, treatment and care falling under the practice guidelines of the American Occupational Therapy Association (AOTA), the American Physical Therapy Association (APTA), the American Speech-Language Heritage Association (ASHA) and the State of Tennessee. I acknowledge that there is always a risk of injury with any therapy involving physical activity. I hereby, intending to be legally bound, waive forever all claims for damages against First Steps, Inc., the board of directors, and the employees for any and all injuries and losses, including theft, loss of property, or death that I, my son, daughter or ward may sustain while participating in any and all activities at First Steps, Inc.

By signing this, I acknowledge that I have read and understand the contents and am competent to execute it, or if executed on behalf of another, that I am authorized to execute it on the behalf of that person.

____ ______________________

Parent/Guardian Signature **Date**

____ ______________________

Witness Signature **Date**

Permission to Release/Obtain Medical Information

While a client at First Steps, Inc., I authorize First Steps to release necessary and pertinent medical information to the child's physician, case manager, insurance company, therapist(s), Medicaid and the child's school as needed for my child, ______________________________. I authorize First Steps, Inc. to contact and obtain pertinent medical information from the client's physician, case manager, insurance company, therapist(s), Medicaid and the child's school as needed for the purpose of evaluation and treatment planning.

____ ______________________

Parent/Guardian Signature **Date**

Communication of Medical Information

Child's Name ____________________________ Parent/Guardian(s) Name ____________________________

Work Phone ____________________ Cell Phone ____________________ Home Phone ____________________

May we leave a message on your voicemail? _______ at work _______on cell _______ at home

May we text you? _______ If so, at what phone number(s)? ____

Medical information may be given to the following persons: ______________________________________

____ ____

____ ______________________

Parent/Guardian Signature **Date**

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Attendance Policy

Attendance is critical for your child to receive the optimal services that First Steps has to offer. For your child to receive the most benefit, it is important that he or she attend sessions regularly. We, however, understand that there may be times it necessary for your child to miss a session. Acceptable reasons for cancellations include illness, unexpected medical appointments, and unexpected family emergencies. First Steps cannot make exceptions for children taking extended vacations.

We request that whenever possible a 24 hour notice be given when you need to cancel a therapy session. Your child may be discharged from services if you miss two appointments with less than a 24 hour notice within a month, or if you have five or more cancellations, for any reason, within two months.

If a First Steps Therapist needs to cancel or reschedule a session due to unforeseen circumstances, you will be notified as soon as possible. Please make sure to keep your contact information up to date with your Therapist. He/she will make every effort to reschedule cancelled appointments.

I have read the attendance requirements and understand that my child's continued enrollment is dependent upon regular attendance.

____ ________________

Parent/Guardian's Signature **Date**

Permission to Photograph

Date photo/video will be taken ___ongoing while child is enrolled in First Steps, Inc. Therapy Program___

Child's name ______________________ Agency taking photo/video ___First Steps, Inc.___

First Steps staff will occasionally take photos/video of the children for internal agency use only. Examples of this include but are not limited to: classroom displays; child's record; instructional purposes; parties/special events.

_____ Yes, my child may be photographed/videotaped for this purpose.
_____ No, my child may NOT be photographed/videotaped for this purpose.

____ ________________

Parent/Guardian Signature **Date**

Photographs and videotaped media are sometimes used by First Steps in promotional materials including brochures, flyers, display materials, newsletters, conferences and other media format. If you do not wish for your child's photograph to be used in promotional materials as described above, please check NO below.

_____ Yes, my child may be photographed/videotaped for this purpose.
_____ No, my child may NOT be photographed/videotaped for this purpose.

____ ________________

Parent/Guardian Signature **Date**

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First Steps, Inc. – Therapy Program
Family Report

Child's Name ____ Date of Birth ____________________

Names of Family Members (living in same household w/child), and ages of siblings: ________________________
____

It will be helpful for your child's therapist(s) to know a little about the goals you have for your child.

What are your priorities in coming months for your child? ____________________________________
____
____
____

What are your expectations of your child's therapist? ______________________________________
____
____
____

Does your child have an Individualized Family Service Plan (IFSP) or an Individualized Education Plan (IEP)? ____

If your child has an IFSP or an IEP, please ensure your therapist has access to this plan.

Financial Responsibility

First Steps, Inc. insures fiscal accountability by establishing a sound reimbursement plan for services provided to all families that we serve. First Steps' families are responsible for providing correct financial information for payment on all account balances in a timely manner. Notification of changes must be made no later than three (3) business days before the draft dates of the chosen payment plan. Our fee schedule is attached. Our policies and procedures related to insurance and self-payments are outlined in our Family Handbook. We ask that you review those documents carefully before signing this form.

I hereby authorize First Steps, Inc. to bill my insurance company for direct reimbursement of therapy services rendered to my child. I agree to pay the unpaid balance after receipt of invoice from First Steps, Inc. I understand that clients with deductibles/co-pays will be required to pay for the cost of each therapy session on the day that services are rendered until the deductible is met.

I have read, understand and agree to adhere to the financial policies and procedures outlined in First Steps Therapy Program Family Handbook.

____ ____________________
Parent/Guardian Signature **Date**

____ ____________________
Witness Signature **Date**

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Therapy Program Family Handbook

I have received, read and understand the policies and procedures outlines in First Steps Therapy Program Family Handbook.

____ ____________________

Signature of Parent or Guardian **Date**

Grievance Policy and Procedure

First Steps, Inc. is committed to providing the highest quality services to all children and their families. In the best of situations, differences of opinion can occur. Our goal is to resolve differences with minimum disruption to service delivery.

Grievance Policy
Parents have the right to voice complaints about the program and/or operation of First Steps, Inc. If a parent is dissatisfied, he or she should follow the procedures below.

1. If a parent is not satisfied with First Steps, the parent may request a meeting with the Program Director. (If the complaint is about the Program Director, the parent may request a meeting with the Director of Operations.) The Program Director will meet with you and respond in writing within 5 working days of the request for a meeting.

2. If the parent is not satisfied with the response from the Program Director, the parent may request a meeting with the Director of Operations or the Executive Director. The Director of Operations or Executive Director will meet with you and respond in writing within 5 working days of the request for a meeting.

3. If the parent is not satisfied with the response from the Director of Operations or Executive Director, the parent may contact the Board President to request a meeting with the Human Rights (HR) Committee of the Board of First Steps, Inc. The HR Committee will meet with you within 30 working days of the request for a meeting and will respond in writing no more than 10 days after the meeting.

4. If the parent is not satisfied with the response from the HR Committee, the parent may request a meeting with the Board of Directors of First Steps, Inc. by contacting the Board President. The Board will meet with you within 30 working days of the request for a meeting. The President, Executive Committee, and a representative from the Department of Education or the Department of Mental Health and Developmental Disabilities will attend. The representative will act as a consultant for both parties. The President of the Board will respond in writing no more than 10 days after the meeting. The decision of this group is final.

We hope to resolve differences as quickly as possible. There will be no repercussions for families who choose to complete any or all steps.

____ ____________________

Signature of Parent or Guardian **Date**

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First Steps, Inc. – Therapy Program
Notice of Privacy Practices

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review carefully.

We care about the privacy of the clients we serve, and strive to protect confidentiality of medical information. You have the right to the confidentiality of your child's medical information and to the privacy of their protected health information. We abide by the terms of the Notice of Privacy Practices currently in effect and we provide notice of privacy practices, by us, with respect to protected health information. If you have any questions about this notice, please contact our Business Office.

Who Will Follow This Notice
Any health care professional authorized to have access to your child's medical records, all employees, staff, and other personnel at First Steps, Inc. who may need access to information must abide by this Notice. Only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About Your Child
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment
We may use medical information about your child to provide medical treatment or services.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization
- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health and safety
- In response to a legal proceeding
- As required by the US Food and Drug Administration
- Other healthcare providers treatment activities
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

Acknowledgement of Receipt of Notice of Privacy Practices
By signing this form, you acknowledge receipt of the First Steps, Inc., Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI)about your child and your rights regarding the use and disclosure of PHI. We encourage you to read it in full.

I acknowledge the receipt of the First Steps, Inc., Notice of Privacy Practices.

Print Child's Name ______________________________
Print Parent/Legal Guardian's Name ______________________________
Signature of Parent/Legal Guardian ______________________________ Date ______________
Relationship to Child ______________________________