Across the Board THERAPY GROUP
SPEECH • BEHAVIORAL/ABA • OCCUPATIONAL • PHYSICAL

7552 Navarre Parkway, Unit 32
Navarre, Florida 32566
Phone: 850-939-3944
Fax: 850-939-3945

General Information:

Patient Name	Date of Birth	Age	Gender (M / F)

Person Providing Information	Relationship to Patient	Date

Address:		
Apartment:		
City:	State:	Zipcode:
Phone Number:		

Does the child live with both parents? YES / NO

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Emergency Contact	Relationship to Patient	Phone Number

Primary Care Physician: _____
Referred for: Occupational Therapy / Speech Therapy

Primary Insurance:
ID #:
Group #:
Phone Number:

Secondary Insurance:
ID #:
Group #:
Phone Number:

Medical Diagnoses Received: _____
_____

Sibling's Name	**Sibling's Age**

Is there any known history of the following the immediate or extended family?

Autism/ PDD	ADHD	Learning Disability
Hearing Loss	Stuttering	Speech/Language Delay

Please explain: _____
_____
_____

Concerns:

1. What are your current concerns? _____
_____

2. When did you first have concerns about your child? _____

3. What specific skills would you like your child to achieve in therapy? _____
_____

Pregnancy and Birth History:

If you answer "yes" to any question, please explain in the space provided below.

1. Were there any illnesses, injuries, bleeding, or other complications during your pregnancy? YES / NO

2. Was your pregnancy full term? YES / NO (Gestational Age _____)

3. Was labor and delivery normal? YES / NO

4. What was your method of delivery? VAGINAL / CESAREAN / BREECH

5. Were forceps used? YES / NO

6. Was suction used? YES / NO

7. Was oxygen or respiratory assistance required after birth? YES / NO

_____
_____
_____
_____
_____

Feeding History:
If you answer "yes" to any question, please explain in the space provided below.

1. Has your child experienced any complications with feeding? YES / NO

2. How was your child fed as an infant? BOTTLE / BREAST
- Until what age were they fed this way? _____

3. Do you have concerns regarding your child's feeding habits? YES / NO

_____
_____
_____

Medical History:
If you answer "yes" to any question, please explain in the space provided below.

1. Please check any and all of the following that your child has experienced.

____ Chicken Pox	____ Cleft Lip/ Palate	____ Vision Problems
____ Seizures	____ Gastroesophageal Reflux	____ Feeding Tube
____ Ear Infections	____ Fluid in the Ears	____ PE Tubes
How many? ____		When? ____

2. Is your child currently taking any medications? YES / NO

3. Does your child have any known food allergies? YES / NO

4. Does your child have any known drug allergies? YES / NO

5. Has your child's hearing been evaluated? YES / NO
When: _____
By Whom: _____
Results: _____

6. Has your child received therapy in the past? YES / NO
Speech / Occupational / Physical / Other
Where: _____
When: _____

7. Are there any other precautions, not described above, of which we should be aware? YES / NO

_____
_____
_____

Speech/Language Development:

1. What are your child's primary modes of communication? *Please check all that apply.*

___ Signing ___ Single words ___ Sentences ___ Picture exchange
___ Gestures ___ Short phrases ___ Augmentative device

2. If your child is talking, please indicate at what age your child began to:

_____ Babble _____ 2-3 word phrases
_____ First word _____ Use words more than gestures

3. Please given an estimate of how many words are in your child's vocabulary.

_____ Receptive Language -- Words Understood
_____ Expressive Language -- Words Spoken

4. How much of your child's speech do you understand?

10% or less 11-24% 25-50% 51-74% 75-100%

5. How much of your child's speech do others understand?

10% or less 11-24% 25-50% 51-74% 75-100%

6. Does your child demonstrate frustration when he/she is not understood? YES/NO
If yes, please explain in the space below.

_____
_____
_____

Play and Social Skills:

1. Does your child engage in eye contact during communication? YES/NO/SOMETIMES

2. When given a choice, does your child prefer to play alone or with others? How does your child interact with others? (e.g., aggressive, cooperative) ALONE / WITH OTHERS

_____
_____

3. Does your child:
   - Answer questions logically? YES / NO / SOMETIMES
   - Greet people arriving or leaving? YES / NO / SOMETIMES
   - Engage in turn taking? YES / NO / SOMETIMES

- Initiate conversation? YES / NO / SOMETIMES
- Maintain a topic? YES / NO / SOMETIMES
- Recall and tell about everyday events? YES / NO / SOMETIMES
- Follow one-step directions? YES / NO / SOMETIMES

4. What are some of your child's favorite toys and/or special interests?
_____
_____
_____

Education:

1. Does your child attend school or day care? YES / NO
If yes, where? _____ How often? _____

2. What grade is your child in at the present time? _____

3. Please check any services your child currently receives at school.
____ Speech Therapy ____ Tutoring ____Physical Therapy
____ Occupational Therapy ____ Other _____

4. May we communicate with the school therapists to collaborate services? YES / NO
If yes, please list their information on the "Consent for Release" form and provide a copy of your child's most current IEP.

5. Does your child experience any specific challenges in school? YES / NO
If yes, please explain. _____
_____
_____

Additional Comments:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Across the Board Therapy Group LLC Policies

Attendance.
At Across the Board Therapy Group, scheduled appointments are a bond between our therapists and our patients. This is our opportunity to provide the highest standard of care to each patient. To help us honor our commitment to your care, we ask all families to follow a few simple guidelines:

1. Arrive for your appointment on time
2. Provide at least a twenty four (24) hour notice for cancellations
3. Limit number of cancellations
4. Honor our bond

We realize that emergencies happen and schedules change. However, appointments that ware habitually missed, cancelled, or changed will result in one of the following actions:

1. Loss of your regular appointment time
2. Reduction in number of weekly appointment
3. Discharge from this facility as a result of poor attendance

If we feel attendance patterns are habitually not meeting our expectations, we reserve the right to initiate the able procedures at our discretion. No show appointments will result in a $25.00 charge. That charge is not covered by insurance and will be the responsibility of the guarantor on the account. Failure to pay the charge will result in discharge from this facility. Cancelations at or during your scheduled therapy session are considered a no show.

Illness.
If your child is sick please do not bring him/her to therapy until they are sufficiently well. Some of our patients may be medically fragile, therefore, do not bring sick siblings in the Clinic either.

Payment.
Unless other arrangements have been made, payment is due at the time of the service. Medical records will not be released if there is an outstanding balance.

Clinic.
Parents are to remain at the Clinic during their child's services. If it is necessary to leave, the parents must provide a phone number where they can be reached. Typically pediatric sessions are every 30 minutes, therefore, parents are asked to be present five (5) minutes prior to the end of the session to discuss their child's progress and home activities.

Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____
Date: _____

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: _____
Signature of Legal Representative: _____
Date: _____

CONSENT TO TREATMENT

I hereby consent to ACROSS THE BOARD THERAPY, LLC, to furnish therapy services to_____ as prescribed by the physician. I hereby authorize payment directly to ACROSS THE BOARD THERAPY, LLC, of the individual or group insurance benefits specified and otherwise payable to me. I understand I am fully responsible to ACROSS THE BOARD THERAPY, LLC, for all charges not paid by my insurance provider. ACROSS THE BOARD THERAPY, LLC, is authorized to release to said insurance companies, to Transworld Systems, Inc. any/all information listed above and/or medical records.

Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____
Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: _____
Signature of Legal Representative: _____
Date: _____
Name of Witness: _____
Signature of Witness: _____

CONSENT TO RELEASE INFORMATION

Patient's Name:	
Patient's Date of Birth:	
Patient's Address:	
Patient's Biological Parents' Names:	

I authorize Across The Board Therapy, LLC, to release and/or obtain information about the above patient from:

Primary Care Physician:	Address:	Telephone:	Facsimile:
Insurance Company:	Policy Number:	Address:	Telephone:
School District:	Address:	Telephone:	Facsimile:
Teacher:	Address:	Telephone:	Facsimile:
Other:	Address:	Telephone:	Facsimile:

Signature of Parent/Guardian: _____
Date: _____

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: _____
Signature of Legal Representative: _____
Date: _____
Name of Witness: _____
Signature of Witness: _____

Notice of Privacy Practices
How Your Medical Information Is Used

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

This Notice applies to ACROSS THE BOARD THERAPY GROUP, LLC ("ACROSS THE BOARD"). ACROSS THE BOARD will use and distribute this Notice as its Notice of Privacy Practices and follow the information practices described in this Notice when using or disclosing records and information. It will share your health information as allowed and necessary, to carry out treatment, payment, or health care operations as described in this Notice.

Understanding Your Health Information

Each time you visit a hospital, clinic, physician, or other health care provider, a record of your visit is made. Typically, this health record contains your medical history, symptoms, examination and test results, diagnosis, treatment, care plan, insurance, billing, and employment information. This health information, often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among the many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed services.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your health information during your lifetime and for years following your death.
- Provide you with an additional current copy of our Notice upon request.
- Abide by the terms of our current Notice.
- Notify you following a breach of unsecured protected health information in the event you are affected.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

Uses And Disclosures Without Your Written Authorization

We may use and disclose your health information without your written authorization for Treatment, Payment and Health Care Operations

We will use and disclose your health information for treatment purposes

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment. Health care team members will communicate with one another personally and through the health record to coordinate care provided. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you in the future.

We will use and disclose your health information for payment purposes

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may disclose health information about you to other qualified parties for their payment purposes. For example, if you are brought in by ambulance, we may disclose your health information to the ambulance provider for its billing purposes.

We will use and disclose your health information for health care operations

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of health care we provide. In some cases, we will furnish your health information to other qualified parties for their health care operations. The ambulance company, for example, may want information regarding your condition to help them know whether they have done an effective job of stabilizing your condition.

Health Information Exchange

We may make your protected health information available electronically through an information exchange service to other health care providers, health plans and health care clearinghouses that request your information. Participation in information exchange services also lets us see their information about you.

Teaching

Residents, fellows, and students in medicine, therapy, allied health and graduate studies, may be assisting with your care under the supervision of a licensed health care provider as a part of their professional health care training program.

Other Uses and Disclosures of your health information Without your Written Authorization

Notification

We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

Communication With Family and Others

We may disclose relevant health information to a family member, friend, or other person involved in your care. We will only disclose this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf.

Directory

Unless you notify us that you object, or we are otherwise prohibited by law, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy, and, except for religious affiliation, to other people who ask for you by name.

Business Associates

There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform such services. However, we require the business associate to appropriately safeguard your information.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives

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

Fundraising

We may use and disclose your health information to our business associates and affiliated foundations for fundraising purposes. We may contact you in an effort to raise money for clinical programs, research and education. If you do not want us to contact you for fundraising efforts, you must notify ACROSS THE BOARD immediately.

Public Health

We may disclose health information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability;
- To appropriate authorities authorized to receive reports of abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- With parent or guardian permission, to send evidence of required immunizations to a school.

Workers' Compensation

We may disclose health information to the extent authorized and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Correctional Institutions

If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose to the correctional institution, its agents or the law enforcement official your health information necessary for your health or the health and safety of other individuals.

Law Enforcement

We may disclose your health information for law enforcement purposes:

- At the request of a law enforcement official and in response to a subpoena, court order, investigative demand or other lawful process;
- If we believe it is evidence of criminal conduct occurring on our premises;
- If you are a victim of crime and we obtain your agreement, or under certain circumstances, if we are unable to obtain your agreement;
- To identify or locate a suspect, fugitive, material witness or missing person;
- To alert authorities that a death may be the result of criminal conduct;
- To report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

Health Oversight Activities

We may disclose health information for health oversight activities authorized by law. For example, oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Threats to Health or Safety

Under certain circumstances, we may use or disclose your health information if we believe it is necessary to avert or lessen a serious threat to health and safety and is to a person reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

Specialized Government Functions

We may disclose your information for national security and intelligence activities authorized by law, for protective services of the president; or if you are a military member, to the military under limited circumstances.

As Required by Law

We will use or disclose your health information as required by federal, State or local law.

Lawsuits and Administrative Proceedings

We may release your health information in response to a court or administrative order. We may also provide your information in response to a subpoena or other discovery request, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Funeral Directors, Medical Examiners, and Coroners

We may disclose your health information to funeral directors, medical examiners, and coroners consistent with applicable law to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Incidental Uses and Disclosures

There are certain incidental uses or disclosures of your health information that occur while we are providing services to you or conducting our business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

Uses And Disclosures That Require Your Written Authorization

The following uses and disclosures will only be made with your written authorization:

- Uses and disclosures not listed above as permitted without your written authorization;
- most uses and disclosures of psychotherapy notes;
- uses and disclosures for our marketing purposes; and
- disclosures that constitute a sale of your health information.

Your authorization may be revoked in writing at any time except with respect to any actions we have taken in reliance on it.

Your Health Information Rights

You have the following rights regarding your health information:

Right to Inspect and Copy

You may request to look at your medical and billing records and obtain a copy. You must submit your medical records request to the Health Information Management Department. Contact the office listed on your billing statement to request a copy of your billing record. If you ask for a copy of your records, we may charge you a copying fee plus postage. If we maintain an electronic health record about you, you have the right to request your copy in electronic format.

Right to Request Amendment

You may request that your health information be amended if you feel that the information is not correct. Your request must be in writing and provide rationale for the amendment. Please send your request to the Health Information Management Department. We may deny your request, and will notify you of our decision in writing.

Right to an Accounting of Disclosures

You may request an accounting of certain disclosures of your health information showing with whom your health information has been shared (does not apply to disclosures to you, with your authorization, for treatment, payment or health care operations, and in certain other cases).To request an accounting of disclosures, you must send a written request to Across the Board. Your request must state a time period that may not be longer than six years.

Right to Request Restrictions

You may request restrictions on how your health information is used for treatment, payment or

health care operations or disclosed to certain family members or others who are involved in your care. We may deny your request with one exception. If we agree to a voluntary restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment. We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes, if you pay in full for all expenses related to that service prior to your request and the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction. To request a restriction, you must send a written request to Across the Board, specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.

Right to Request Private Communications

You may request that we communicate with you in a certain way in a certain location. You must make your request in writing to the patient registration staff and explain how or where you wish to be contacted.

Right to a Paper Copy of this Notice

You may request an additional paper copy of this Notice at any time.

Complaints

You may complain to us or to the Secretary of Health and Humana Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against your for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask us to explain. Signature below confirms acknowledgment of our Privacy Practices

We reserve the right to change this Notice as our privacy practices change and to make the new provisions effective for all health information we maintain.

Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____
Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: _____
Signature of Legal Representative: _____
Date: _____
Name of Witness: _____
Signature of Witness: _____

HIPAA RELEASE OF INFORMATION
AUTHORIZATION FORM

I, _____hereby authorize ACROSS THE BOARD THERAPY GROUP, LLC, and its affiliates, its employees and agents (collectively "ACROSS THE BOARD"), to release to _____ my personal health information maintained by ACROSS THE BOARD (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire on the date my coverage ends with ACROSS THE BOARD.

I understand that I have a right to revoke this authorization by providing written notice to ACROSS THE BOARD. However, this authorization may not be revoked if ACROSS THE BOARD, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____
Date: _____

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Signature of Legal Representative: _____
Date: _____
Name of Witness: _____
Signature of Witness: _____