Welcome to Brooker Memorial's Center for Children's Therapy

Welcome to Brooker Memorial, a non-profit community organization dedicated "To preparing children for life-long success through education, health services, family support and programs of excellence." Our child care, pediatric dental, and Center for Children's Therapy programs serve all of Litchfield County.

Thank you for choosing the Center for Children's Therapy at Brooker Memorial. We look forward to seeing you and your child at Brooker! Enclosed in this packet, you will find several forms for you to complete before your first appointment. This will allow time for the therapist to read over the documents and help with your child's evaluation. You may print the completed forms and bring them with you to your first visit, or upload the documents directly to our patient portal.

Please contact me directly if you have any questions or concerns at 860-489-1328 ext. 129. We look forward to seeing you soon!

Thank you.

Cassandra Weik, LCSW

Cassandra Weik, LCSW
Director of Children's Therapy and Family Support

Informed Consent for Evaluation & Treatment

I, ____________________the parent/legal guardian of ____________________ hereby request and consent the Brooker Memorial Center for Children's Therapy to perform evaluation, treatment and care for my child as prescribed by a physician and/or recommended by a licensed therapist.

I understand and I am informed that, as in the practice of medicine, occupational therapy, speech therapy and physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my child's condition prior to treatment.

I acknowledge and agree that a parent or legal guardian must be present during each treatment session.

I have carefully read and fully understand this informed consent and have had the opportunity to discuss it with the treating therapist.

I consent and authorize the Brooker Memorial Center for Children's therapy to administer treatment under the direction and supervision of a licensed therapist.

______________________________ ____________________

Signature of Parent/Legal Guardian Date

By typing your name above, you agree that your typed signature will be used as your actual signature.

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If this happens, we respectfully ask that scheduled appointments be cancelled at least 24 hours in advance.

Our therapists want to be available for your needs and the needs of all our patients. When a patient cancels or does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce it as follows.

- If you cancel within three hours of your appointment or no-show for an appointment three times in a 12 month period, we your therapist will discharge you from the center. A discharge letter will be sent to you after the third occurrence.
- If we do not hear from you over three consecutive weeks, we will assume you are no longer interested in scheduling a visit and your therapist will discharge you from the center. A discharge letter will be sent to you.
- If you are discharged, you will have the option to be placed on the waiting list.
- If you are more than 15 minutes late for your appointment without prior notice, you may not be able to be seen. If you are able to be seen, your appointment may not be full length due to other patient appointments that are scheduled after yours.

Our goal at The Center for Children's Therapy is to make sure that the children in our practice get the very best care. This is a team effort between our staff and your family.

Thank you for your understanding and cooperation as we institute this policy.

Cassandra Weik, LCSW

Cassandra Weik, LCSW
Director of Children's Therapy and Family Support

____
Patient Name

________________________________ ____________
Parent/Guardian signature Date
By typing your name above, you agree that your typed signature will be used as your actual signature.

Brooker Memorial
Preparing Children for Life-long Success

Conditions of Treatment

USE AND DISCLOSURE OF HEALTH INFORMATION FOR PAYMENT PURPOSES: I authorize Brooker Memorial Center for Children's Therapy to disclose diagnoses and other pertinent information, including information relating to treatment. This release is for purposes related to payment for services rendered to my child, ________________________________. I authorize the release of information to my insurance provider(s). This authorization serves to release my treatment information for the purpose of payment. This authorization may be revoked at any time except to the extent that action has been taken in reliance thereon.
PRE-CERTIFICATION, ASSIGNMENT OF INSURANCE BENEFITS: The undersigned, promises to pay the amount due for services rendered. I accept responsibility for making sure that all prior authorizations have been obtained, and that any other procedures required by my child's insurance provider before Brooker Memorial Center for Children's Therapy renders services have been or will be followed. I agree to be responsible for any amount not paid by insurance.
MEDICAID/HUSKY/COMMERCIAL INSURANCE CERTIFICATION: I certify that the information given by me in applying for payment by Medicaid/Husky, or commercial insurance is correct. I request the payment of authorized benefits be made on my child(s) behalf. I assign the benefits payable to Brooker Memorial Center for Children's Therapy and authorize Brooker Memorial Center for Children's Therapy to submit claims to payer's on my behalf.
SEL-PAY: I agree to be responsible for all therapy fees, and/or to work with the Center's Coordinator prior to my first scheduled appointment to arrange a payment plan.
COPAY: I agree to make all required copays and deductibles as indicated by my insurance company.
OUT-OF-NETWORK: I understand that Brooker Memorial Center for Children's Therapy may not be in network with my insurance company and I agree to make all payments for services rendered to my child.
Insurance coverage is not a guarantee of payment, it is the parents/guardians responsibility to know their insurance coverage. There are times when insurance may state OT/PT/Speech Therapy is covered, however, the insurance company may deny coverage at any time and therefore deny payment. The office coordinator will be happy to assist with this process when possible.

Signature of Parent/Guardian: ________________________________
Date: ________________

By typing your name above, you agree that your typed signature will be used as your actual signature.

Consent for Use of Photograph

I, ________________________________ give my permission for photographs or video of my child(ren): ________________________________ to be used for publicity purposes for Brooker Memorial including but not limited to: local newspapers, Brooker Annual reports, Brooker's website, digital marketing, video, brochures, Brooker display boards and bulletin Boards.

☐ I agree that my child's name may be used in conjunction with the photo.

☐ I do not wish to have my child's name used in conjunction with the photo

☐ I do NOT give permission for my child's photograph or likeness to be used for publicity purposes.

☐ My child's photo may only be used in house.

Signature: ______________________________

Date: ______________________________

This consent may be revoked at any time with your written request. Once revoked, additional photos will not be used for the above referenced purpose. Photos already in print will not be rescinded but future reprints of these items will not include your child's photograph.

By typing your name above, you agree that your typed signature will be used as your actual signature.

Fusion Patient Portal

Dear Center for Children's Therapy Parent,

Brooker Memorial would like to use your email address to send you updates on our programs and to provide you access to our Patient Portal. By providing us with your email, you will receive information regarding new programs, activities and news at Brooker, helpful resources, policy changes, etc. Our Patient Portal allows you to view and download your child's evaluations and documents, home exercise programs, and see your upcoming appointments.

Please sign below to indicate your wishes in being a part of these updates.

☐ Yes! Please use this email address to keep me informed:
____

☐No, thank you.

My child's name is: ______________________________________

______________________________________ ________________
Parent/Guardian Signature Date

By typing your name above, you agree that your typed signature will be used as your actual signature.

Health Insurance Portability and Accountability Act of 1996

HIPAA OMNIBUS
NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003
Revised: December 4, 2018

Privacy Officer: Sandy Lepage
Email: slepage@brookermemorial.org

HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at **brookermemorial.org** or calling the Privacy Officer at **860-489-1328**.

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:
We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

<u>Right to Amend Records</u>. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

<u>Right to an Accounting of Disclosures</u>. You have a right to request an "accounting of disclosures" every 12 months, <u>except</u> for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

<u>Right to Receive Notification of a Breach</u>. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

<u>Right to Request Restrictions</u>. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

<u>Right to Request Confidential Communications</u>. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

<u>Right to Have Someone Act on Your Behalf</u>. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

<u>Right to Obtain a Copy of Notices</u>. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

<u>Right to File a Complaint</u>. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at **860-489-1328**, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

<u>Use and Disclosures Where Special Protections May Apply</u>. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

______________________________ __________________
Parent/Guardian Signature Date

By typing your name above, you agree that your typed signature will be used as your actual signature.

Patient Information

Date: ________________ **Date of Birth**: ____________________

Patient Name: _____________________________________**Male**: ☐ **Female**: ☐
Primary Address: ____

City: ________________________ **State**: _______ **Zip**: _______

Phone Numbers: **Home**: ____________________ **Cellular**: ____________________

Email address: ____

Name of parent/guardian: ____________________ **Parent DOB**: ________________

Relationship to patient: ____________________ **Occupation**: ____________________

Emergency Contact Name: ____________________ **Phone Number**: ____________________

Relationship to Patient: ____________________

Does the patient have insurance: ☐Yes ☐No

Policy/Medicaid Number: ____________________

Patients SSN: ____________________ **Policy Holders SSN:** ____________________

Referred by: ____

List family/relatives/individuals Brooker Memorial may discuss treatment plans with and that can make medical decisions on parent's behalf should the parent not be present:

____

Medical History Questionnaire

Patient's Name: ____________________ Date of Birth: ____________________
Email: ____

1. **Does the patient have any health problems?** ☐Yes ☐No
   If Yes, explain ____________________
2. **Is the patient currently seeing a physician for any problems?** ☐Yes ☐No
   If Yes, explain ____________________
3. **Did the patient have any health problems or illnesses when younger or at birth?** ☐Yes ☐No
   If Yes, explain ____________________
4. **Does the patient take any medications?** ☐Yes ☐No
   If Yes, explain ____________________
5. **Has the patient ever had any allergic or bad reactions to food or medicines?** ☐Yes ☐No
   If Yes, explain ____________________
6. **Has the patient ever been injured or stayed in the hospital overnight?** ☐Yes ☐No
   If Yes, explain ____________________
7. **Has the patient ever had a blood transfusion** ☐Yes ☐No
8. **Has the patient ever had any of the following?**
   - blood problems such as sickle cell anemia ☐Yes ☐No
   - easy bleeding or bruising ☐Yes ☐No
   - seizures or fainting spells ☐Yes ☐No
   - frequent headaches ☐Yes ☐No
   - heart murmur, heart defect or rheumatic fever ☐Yes ☐No
   - breathing problems or asthma ☐Yes ☐No
   - frequent cough or tuberculosis (T.B.) ☐Yes ☐No
   - hepatitis or liver problems ☐Yes ☐No
   - stomach or bowel problems ☐Yes ☐No
   - diabetes (sugar), endocrine or hormone problems ☐Yes ☐No
   - kidney problems ☐Yes ☐No
   - hives or skin rash ☐Yes ☐No
   - AIDS or HIV infection ☐Yes ☐No
   - venereal disease ☐Yes ☐No
   - birth defect or disability ☐Yes ☐No
9. **Does the patient have any behavior or learning problems?** ☐Yes ☐No
10. **What grade at school is the patient in?** ____________________

11. **Who takes care of the patient at home?** ____________________
12. **Has the patient had any disease, condition or problem not listed above?** ☐Yes ☐No
    If Yes, explain ____________________
13. **Is the patient presently smoking, vaping, chewing or snuffing tobacco**? ☐Yes ☐No
    If Yes, explain ____________________

Name of the patient's pediatrician or family physician ____________________

Address ____________________

Phone # ____________________

Date of last physical examination: ____________________

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

(PLEASE SIGN BELOW)

______________________________ ____________________

Signature of Parent/Legal Guardian Date

______________________________ ____________________

Signature of Reviewer Date

By typing your name above, you agree that your typed signature will be used as your actual signature.

Developmental History Questionnaire

Thank you for taking the time to fill out this form. Your answers will help our staff get to know and understand your child and better meet their needs.

Family Structure

Mother's/Guardian's Name ___________________ ☐ Living with child ☐Not living with child

Father's/Guardian's Name ___________________ ☐Living with child ☐Not living with child

Parents are: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

☐Other ___________________

Who are members of your child's family/household?

Name	Age	Relationship
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________

Is there anything else you would like us to know or be aware of with regards to your child's family?

____

Pregnancy and Birth History

Is your child adopted? ☐Yes ☐No If yes, at what age? ______

Complications during pregnancy? ____

☐Full-term ☐Premature at _____ weeks

Complications during birth? ____

Child's weight at birth _______ lbs. ________ oz.

Child's health at birth ____

Was your infant ☐Calm ☐Fussy ☐Colicky ☐Easily comforted ☐Hard to comfort?

Describe: ____

Did your child have any difficulties with: ☐Feeding ☐Sleeping ☐Bonding ☐Other?

Describe: ____

Has your child ever has a serious accident/illness or hospitalization? ☐Yes ☐No

Describe: ____

Did/does your child have recurrent ear infections? ☐Yes ☐No

Have tubes in his/her ears? ☐Yes ☐No

Has your child had a ☐Hearing Screening ☐Vision Screening ☐Yes ☐No

Outcome/Approximate Dates: ____

Developmental Milestones

As accurately as you can remember, how old was your child when s/he:

Rolled Over: ______ Sat Up: ______ Crawled: ______ Walked: ______

Talked (2 Words): ______ Weaned (bottle/breast): ______ Fed self (spoon): ______

Drank from a cup: ______ Toilet trained: ______

Was/Is your child fed by? ☐g-tube ☐bottle ☐breast fed **How long?** ______

Does/Did your child: ☐use a pacifier ☐suck thumb **How long?** ______

How would you describe your child's feeding/diet? ☐Normal ☐Picky Eater

☐Restricted Diet ☐Poor Nutrition

List preferred foods, concerns: ____

Do you have concerns about your child's development in any of these areas? ☐Speech or Language ☐Motor Skills ☐Social Skills ☐Learning ☐Sensory ☐Behavioral ☐Emotional

Describe: ____

Does your child have any developmental delays or special needs? ☐Yes ☐No

Describe: ____

Has your child had a developmental or diagnostic assessment? ☐Yes ☐No

List (name of facility or doctor, date, results):

____

Daily Routine

Eating: Does your child feed him/herself with utensils? ☐Yes ☐No

Describe Concerns: ____

List typical eating/feeding times: ____

Diapering/Toileting: Is your child toilet trained? ☐Yes ☐No ☐In Progress

Describe Concerns: ____

Dressing/Hygiene/Grooming: Does your child get dressed by themselves? ☐Yes ☐No ☐In Progress

Describe Concerns: ____

Any difficulties with tooth brushing, hand washing, washing hair, bathing, showering?

☐Yes ☐No Describe Concerns: ____

Any difficulties with hair brushing, haircuts, or nail trimming? ☐Yes ☐No

Describe Concerns: ____

Sleeping: Describe your child's sleeping arrangement: _________________________

Does your child go to sleep: ☐easily ☐with difficulty ☐with a bottle ☐with a parent ☐have a bedtime routine?

Describe: ____

Does your child have a regular bedtime? ☐Yes ☐No Wakes at: ______ Naps at: ______

Goes to bed at: ______

Activities and Play: What are your child's favorite activities at home?

____

Where does your child usually play? ___________________________________

Does your child avoid any physical activities? ☐Yes ☐No

Describe: ____

Does your child attend any regular play groups, sports, or classes? ☐Yes ☐No

Describe: ____

Social Relationships: Does your child usually play: ☐alone ☐w/ siblings ☐w/peers ☐w/ younger children ☐w/ older children ☐w/ adults?

Describe: ____

Temperament and Personality

How does your child handle transitions? ______________________

What works best? ______________________

When does your child get upset/angry? ______________________

How does s/he express anger? ______________________

Describe your child's typical temperament: ______________________

Energy	☐Sedentary ☐Active ☐Very Active Describe: ____________
First Reaction *(to new people, activities, ideas)*	☐Avoidant ☐Shy ☐Outgoing Describe: ____________
Mood *(general emotional tone)*	☐Anxious ☐Timid ☐Curious ☐Serious ☐Happy ☐Other ____________ Describe: ____________
Intensity *(strength of emotional reactions)*	☐Withdrawn ☐Mild reactions ☐Strong reactions Describe: ____________
Sensitivity *(to noises, emotions, tastes, textures)*	☐Not sensitive ☐Mild ☐Very Sensitive Describe: ____________
Adaptability *(copes with transitions, changes)*	☐Rigid ☐Flexible Describe: ____________

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Attention Span/Distractability ☐Easily Distracted ☐Sometimes Distracted ☐ Stays Focused
Describe: ________________

Parents Comments

What do you find the most challenging or stressful in parenting your child?

What has been most joyful for you in parenting your child?

What are your goals for your child?

Is there anything else you would like us to know about your child?

Thank you for taking the time to fill out this form.
Please upload the completed forms to your patient portal.