Patient Registration Form

Patient Information

First Name	M.I.	Last Name		SS#
Mailing Address		City	State	Zip
Phone		Birthdate	Age	Sex (circle one) M F

Responsible Party (If Other Than Patient)

First Name	M.I.	Last Name		SS#
Mailing Address		City	State	Zip
Home Phone	Employer		Work Phone	

Insurance Information

Primary Insurance Company			Phone
Address	City	State	Zip
Insured's Name	Birthdate	ID #	Group #
Secondary Insurance Company			Phone
Address	City	State	Zip
Insured's Name	Birthdate	ID #	Group#

Is this visit a result of a car accident Y N	Date of Accident	Attorney Name:
Drug or Food Allergies:		
What are you main concerns/problems that you want addressed in this evaluation?		
Who can we thank for referring you to us?		

Building Blocks Occupational, Physical, and Speech Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701-3537 Ph: (907) 374-4911 Fax: (907) 374-4934

Building Blocks Policies

Name _____ Date of Birth _____

All of us at Building Blocks understand that things in life happen and that there are times when you will be running late or have to cancel. We want to provide the best care possible for your child, and consistent attendance plays a big role in that care. Therefore, we have put the following policies in place:

Cancellations/Absenteeism

If your child is unable to attend a session, you must call to cancel the appointment. You must call to cancel a minimum of 24 hours before your appointment. If you do not call to cancel the appointment, it is considered a "No Show".

If your child is absent more than 20% of the time in any given month, we will schedule a meeting with you. We will discuss how we can help you improve your attendance rate and what circumstances may be contributing to your attendance. During the meeting, we will better formulate an attendance agreement that will help us provide the best care for your child. This agreement will be created on a case by case basis and will include attendance requirements and consequences. Please note that long absences may result in loss of current appointment time. However, vacations or extended absences will not count against this policy if we are given a minimum of one week notice prior to the absence. Extenuating circumstances will be considered. _____ Initial

Late Drop Off

Your child's session begins on the hour. Our therapists try very hard to be on time to pick up your child for his/her session. Please be early to drop your child off. Your child is considered late even one minute after the hour. _____ Initial

Late Pick Up

Your child's session is concluded 5 minutes before the hour to be able to discuss the session with you and for our therapists to start the next session on time. Just as you would not like your child's session to start late due to the therapist waiting for the previous parent, please be mindful that your tardiness impacts other children's sessions as well. If you are late to pick up your child, we may require you to stay on-site during all sessions.

To be considered "on time", you must be in the waiting room 5 minutes before the end of the session. _____ Initial

No Shows

If you fail to cancel your appointment, you will receive a $50 no-show charge for each therapist scheduled to work with your child. Insurance companies do not pay for no-show fees. Therefore, you will be personally responsible for these fees. After three no-shows, your child will be removed from the therapy schedule. _____ Initial

Therapy at Building Blocks

All of our therapists are nationally certified and state licensed. Your child's initial evaluation will be done by one of our licensed Occupational Therapists (OT), Physical Therapists (PT) and/or Speech-Language Pathologists (SLP). Our experience shows that a child makes better progress when he/she works with a variety of therapists. Therefore, whenever possible, each child will have the chance to work with different therapists within the department that the child receives services. All of the licenses are posted in the waiting area and please feel free to ask any questions you might have. _____ Initial

Building Blocks is a teaching facility. We allow volunteers to observe our therapists to fulfill requirements to be accepted into graduate therapy programs. In addition, we have working relationships with several accredited graduate programs at universities across the nation. We accept high level graduate students to learn under the therapists here at Building Blocks. All volunteers and students are properly supervised at all times. _____ Initial

Confidentiality

We take confidentiality very seriously at Building Blocks. We often have multiple clients working in a therapy room at a time. If you attend a session, we do require you to sign a Visitor/Volunteer Confidentiality Statement form before you are allowed in the session. _____ Initial

Parents/Caregivers are more than welcome to use the time that your child is in therapy to leave and run errands. We do require that you return at least 5 minutes before your child's session is scheduled to end so that your child's therapist can discuss the session and any home exercises we may need you to do. _____ Initial

The focus of therapy is to encourage and challenge your child to participate in new activities of daily life. Use of play equipment is an integral part of your child's therapy and there are inherent risks associated with use of the equipment.

On occasion, your child may participate in off-site therapy at the Nordale Education Center playground across the street. Please understand that there may be other families utilizing the playground at that time.

WAIVER: I understand that as a part of therapy sessions, my child may be involved in activities in a play area or on play equipment. I understand that there is some risk of injury associated with my child participating in activities involving the use of lay equipment. I agree to release, hold harmless, and waive Building Blocks Rehab, LLC., Building Blocks Occupational Therapy, Inc., Building Blocks Speech Therapy, LLC., and/or Building Blocks Physical Therapy, Inc. from and against all claims, injuries, liabilities or damages arising out of or related to my child's use of the play equipment or play area. _____ Initial

Video, Pictures, and Electronic Devices

I understand that Building Blocks utilizes video and pictures for documentation purposes only. All pictures/video are ONLY used for documentation purposes and are not released or used for any other purposes. _____ Initial

Building Blocks uses video monitoring both the interior and exterior of our building for security purposes.

When you accompany your child in session, we require that all personal electronic devices be either be turned off or not taken into the treatment area. This includes cell phones, still cameras, video cameras, tablets, and portable games. _____ Initial

Financial Responsibility

Payment by your insurance company is not guaranteed and is based on the contract between you and your insurance company. Please review your insurance contract for questions regarding occupational therapy, physical therapy, and speech-language therapy coverage. For any returned checks, there will be a charge of $25.00 plus any bank fees. _____ Initial

I understand that I am financially responsible for payment to Building Blocks for charges not covered by my insurance company. I authorize medical benefits to be paid directly to Building Blocks. I also authorize the therapist or insurance company to release any information required for my claims. Co-Pays are due at time of service. In extenuating circumstances, I understand the Building Blocks is willing to work with me on a reasonable payment plan, for which I would need to make arrangements prior to my visit.

Accounts more than 90 days past due will be referred to a collections agent. You will be responsible for all collection fees incurred (35% of balance total), in addition to the past due balance. Building Blocks will not be liable for any consequences which may result from a collections agency's efforts to secure payment.

I have read the above policies and have had my questions answered. This authorization shall expire on written notice.

Signature _____ Date _____

Building Blocks Occupational, Physical, and Speech-Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701Ph: (907) 374-4911 Fax: (907) 374-4934

Consent for Exchange of Information

I give permission to Building Blocks Occupational Therapy, Building Blocks Physical Therapy, Building Blocks Speech, and/or Building Blocks Rehab to exchange information with the following people/agencies regarding _____.
(Patient Name)

Name of person/agency: _____
Address: _____
Phone #: _____

Name of person/agency: _____
Address: _____
Phone #: _____

Name of person/agency: _____
Address: _____
Phone #: _____

Name of person/agency: _____
Address: _____
Phone #: _____

Name of person/agency: _____
Address: _____
Phone #: _____

Signature: _____ Date: _____
(Parent or Guardian – if patient is a minor)

Building Blocks Occupational, Physical, and Speech-Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

Authorizations for non-parental pick-up

I give permission to Building Blocks to release my child _____ to the following people if a parent or guardian is unable to pick them up from therapy.

Name of Person: _____ Phone #: _____

Name of Person: _____ Phone #: _____

Name of Person: _____ Phone #: _____

Name of Person: _____ Phone #: _____

Name of Person: _____ Phone #: _____

Name of Person: _____ Phone #: _____

Parent/Guardian Signature _____Date_____

*Please note that we consider this authorization to also be consent for disclosure about information regarding treatment. The therapist may talk with the person picking up your child about how treatment went that day, behavior, etc. Also note that if it's usually a caregiver or someone other than you bringing and picking up the child, we may send the parents a copy of our reports home with them to give to you.

Client Confidentiality Practices For Visitors and Volunteers

Building Blocks Rehab, LLC, Building Blocks Occupational Therapy, Inc., Building Blocks Physical Therapy, Inc., and Building Blocks Speech Therapy, LLC (referred to as Building Blocks) takes client confidentiality very seriously. Keeping a client's information private involves Building Blocks staff, the client, and visitors to Building Blocks. Clients have a right to privacy and anonymity, and this must be respected. Below are some situations a visitor/volunteer may encounter, the action that should be taken, and the reason for the action.

EVENT	ACTION TAKEN	REASON
You are visiting Building Blocks because you sell or service equipment. In the waiting room, you see one of your best "business contacts"	Approach the client only if the client acknowledges your presence and initiates a conversation with you.	Many clients do not want other people to know that they, or a family member, are receiving therapy services.
The "business contact" initiates a conversation with you. He tells you to stop by his office later. When you arrive later that day, the secretary refuses to interrupt her boss.	Just leave a message that you stopped by. You should not tell the secretary or anyone else who you saw at Building Blocks.	Visitors are prohibited by federal law (Regulation 42CFR Part II) from making any disclosure of information without the written consent of the Building Blocks client.
While volunteering at Building Blocks, you move a box, it accidentally falls, and some client charts fall out. As you are putting the charts back, you recognize a name on one. You are tempted to open the chart.	Do not open the chart. Immediately pick up the charts, put them back into the box they fell out of, close the box, and continue your work. All client information is confidential.	Volunteers are also prohibited by federal law (Regulation 42CFR Part II) from disclosing any information they may be exposed to while visiting or assisting at Building Blocks.
You visit Building Blocks frequently to take your spouse, who works here, to lunch. While waiting in your spouse's office, you overhear a conversation your spouse is having with a client either on the telephone or in person.	While your spouse (the employee) is engaged in the conversation, you should step out of the office until the conversation is over. Any part of the conversation you did hear should be kept confidential by you.	The conversation the employee is having is confidential between the client and the employee; the client did not give consent to having their conversation heard by others.
You are doing your weekly grocery shopping at the local grocery store. You see someone who you have only met because he/she is a client at Building Blocks.	Approach the client only if the client acknowledges your presence and initiates a conversation with you. In your conversation, a general conversation is acceptable but you should not mention anything about Building Blocks.	Many clients do not want other people to know that they, or a family member, are receiving therapy services.

Visitor/Volunteer

Confidentiality Statement

Full Name: _____

Reason for Visit: _____

Duration of Visit: _____

I, the undersigned, understand that any information which is disclosed to me while I am visiting or assisting at Building Blocks is confidential and that this confidentiality is protected by Federal Law. Federal regulation (42CFR Part II) prohibits me from making any disclosure of such information without written consent of the person to whom the information pertains.

I have read the confidentiality examples on the back of this page, and agree to hold in strictest confidence all information of a privileged nature which may be

_____ _____

Visitor Signature Date

_____ _____

Witness Signature Date

Building Blocks Occupational, Physical, and Speech-Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701Ph: (907) 374-4911 Fax: (907) 374-4934

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Building Blocks Occupational Therapy, Building Blocks Physical Therapy, Building Blocks Speech Therapy, and/or Building Blocks Rehab originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Building Blocks Occupational Therapy, Building Blocks Physical Therapy, Building Blocks Speech Therapy, and/or Building Blocks Rehab is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Building Blocks Occupational Therapy, Building Blocks Physical Therapy, Building Blocks Speech Therapy, and/or Building Blocks Rehab reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Building Blocks Occupational Therapy, Building Blocks Physical Therapy, Building Blocks Speech Therapy, and/or Building Blocks Rehab change their notice, they will send a copy of and revised notice to the address I've provided (whether U.S. mail or, if I agree, email)

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient Name Signature (Parent or Guardian – if a minor)

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____on

_____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____

Building Blocks Occupational, Physical, and Speech-Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

Notice of Privacy Practices

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.

At our practice, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective May 1, 2005, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of information for our planning and marketing, and
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of our practice, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request,
- Inspect and copy your health record as provided by 45 CFR 164.524,
- Amend your health record as provided by 45 CFR 164.526,
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.522, and
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (our practice, however, is not required by law to agree to a requested restriction).

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

WE will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, and Health Operations, without your written authorizations, which you may revoke as provided by 45 CFR 164.508(b)(5), Except to the extent that action has already been taken.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer at (907) 374-4911.

If you believe your privacy rights have been violated, you can either file a complaint with our Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services (OSR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The address for the OCR is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building

Washington, D.C 20201

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment.
For example:
We will provide your physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that will show them how you are responsible to treatments.

We will use your health information for payment.
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 will use your health information for regular health 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 the healthcare and service we provide.

- Business Associate
  There are some services provided in our organization through contacts with business associates. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.
- Research
  We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- Public Health
  As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Appointment Reminders
  We may contact you or a family member at the phone number you have provided to us as a reminder that you have an appointment.
- Marketing
  We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Notification
  We may use or disclose Information to notify or assist in notifying a family member or personal representative (or other person responsible for your care) of your location and general condition.
- Communication With Family

We, using our best judgment, may disclose to a family member, other relative, or close personal friend (or any other person you identify) health information relevant to that person's involvement in your care or payment related to your care.

- Law Enforcement
  We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law make provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associated believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standard and are potentially endangering one or more patients, workers, or the public.

Building Blocks Occupational, Physical, and Speech-Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Building Blocks Occupational Therapy, Inc., Building Blocks Physical Therapy, Inc.'s and Building Blocks Rehab LLC **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits wither to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnessed by:** _____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.
Presented on (date and time): _____

By (name and title): _____

Occupational, Physical, and Speech-Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

Allergy Protocol

Child's Name:
DOB:
Parent Name:
Parent Emergency Contact Phone#:

Does your child have allergies? Yes ☐ No ☐
If Yes, please list: _____
_____
_____

What is the procedure we should take if your child has an allergic reaction while in our care?
_____
_____
_____

When should we call the emergency contact number? _____
_____

When should we call 911? _____
_____

Are there any medications we need to administer? Yes ☐ No ☐
If Yes, Where is the medication located?_____
_____

What is the procedure/details about administering the medication?
_____
_____
_____

Parent Signature _____ Date _____

Building Blocks
Occupational
Speech-Language
Physical Therapy
Fairbanks, Alaska
Occupational, Physical, and Speech-Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

Seizure Protocol

Child's Name:
DOB:
Parent Name:
Parent Emergency Contact Phone#:

Does your child have seizures? Yes ☐ No ☐

What is the procedure we should take if your child has a seizure while in our care?_____
_____
_____
_____
_____

When should we call the emergency contact number? _____
_____

When should we call 911? _____
_____

Are there any medications we need to administer? Yes ☐ No ☐

If Yes, Where is the medication located?

What is the procedure/details about administering the medication?

_____
_____
_____
_____

Parent Signature _____ Date _____

Building Blocks Occupational, Physical, and Speech Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701-3537 Ph: (907) 374-4911 Fax: (907) 374-4934

General Information

Child's Name: _____ Date of Birth: _____ Today's Date: _____
Parent(s) Names: _____
Please list everyone who lives in the home with your child:
Parents: _____
Siblings: _____
Other: _____
Diagnosis: _____
Referring Physician: _____
Reason for Referral: _____

How do you prefer information to be provided to you?
☐ Verbal ☐ Written ☐ Both

Background Information

☐ Full Term Pregnancy ☐ No Pregnancy or Birth Complications
Gestational weeks: _____ Birth Weight: _____
☐ Breast Fed ☐ Bottle Fed ☐ Both
Complications during Pregnancy/Delivery: _____
Medications Used During Pregnancy: _____

☐ NICU Reason for NICU: _____
Amount of time in NICU: _____
☐ Premature Birth Number of Weeks Premature: _____
☐ Oxygen Length of time on Oxygen: _____
☐ Feeding Tube Length of time with feeding tube: _____
☐ Jaundice Length of time requiring treatment: _____
Newborn Medications: _____
Newborn Surgeries/Procedures: _____

Delivery
☐ Vaginal Birth
☐ Forceps ☐ Suction ☐ Breech
☐ C-Section

Child's Physician and Health Care Provider Information

Please check **ALL** of the following who your child has seen in the past, is currently seeing, or will be seeing in the future:

□ Pediatrician	□ Ear, Nose, and Throat (ENT)	□ Neurologist
□ Orthopedic Specialist	□ Psych/Counsellor	□ ABA
□ Dietician	□ Care Coordinator	□ Dentist
□ OT	□ PT	□ SLP
□ Opthamologist/Optometrist	□ Vision Therapist	□ Other: _____

Communication:

Primary Language: _____ Language spoken in the home: _____
Speech Therapy Received Elsewhere: _____
My child makes his/her needs known by using: □ Words □ Gestures □ Pointing
My child (check all that apply): □ Is talkative □ Plays alone □ Plays with peers
□ Has friends □ Makes friends easily
Approximately how many words does your child use? _____
Does your child talk in full sentences? □ Yes □ No
Other concerns: _____

Misbehavior:

How is this handles at home: _____
How is this handles at school: _____

Childhood Hospitalizations and/or Surgeries:

Age: _____ Reason: _____
Age: _____ Reason: _____
Age: _____ Reason: _____
Age: _____ Reason: _____

Previous Testing and Treatments

	Assessments			Treatment		
	Yes	No	Place/Date	Yes	No	Place/Date
Hearing Screen						
Audiological Evaluation						
Vision						
Psychological						
Occupational Therapy						
Physical Therapy						
Speech Therapy						
Cognitive/Educational						
Behavioral						

√	Diagnosis	Who Gave the Diagnosis
	ADD	
	ADHD	
	Anxiety Disorder Specify:	
	Cognitive Delay	
	Learning Disabilities Specify:	
	Mood Disorder Specify:	
	Sensory Processing Disorder (SPD) Or Sensory Integration Disorder	
	Other Specify:	

Medical Information

√	Illness/Problem	Age	Frequency/Other Details
	Ear Infections		
	Tubes in Ears		
	Respiratory Problems		
	Cardiac/Heart problems		
	High Fever		
	Adenoid/Tonsil Problems		
	Frequent Colds		
	Food Allergies Specify:		
	Environmental Allergies Specify:		
	Asthma		
	Bronchitis		
	Skin Problems		
	Gastro-Intestinal Problems		
	Reflux		
	Seizures		
	Epilepsy		
	Sleep Problems		
	Broken Limbs		
	Surgeries		
	Hospitalizations		
	Injury to Head or Concussion		
	Other		

Has your child ever had an accident/injury requiring medical attention? □ Yes □ No
If Yes, please explain:

Is your child in good general health at the present time? □ Yes □ No
If No, please explain:

Medications

Please list all medications that your child is **CURRENTLY** taking		
Medication	Dosage	Purpose/Reason

Auditory Development

Has your child had any problems with his/her hearing? (Operations, infections, tubes, etc.)
Ear Infections Frequency: ☐ Never ☐ Seldom ☐ Sometimes ☐ Often Severity ☐ Mild ☐ Moderate ☐ Severe
Are you aware of any current hearing problems?

School

School:	Grade in School:
Teacher:	Type of Classroom:
Does your child have an IEP? ☐ Yes ☐ No	
If Homeschooled, which program are you participating through?	
What Special Services does your child have at school? ☐ **OT** ☐ **PT** ☐ **ST** ☐ **Resource** ☐ **504 Plan** ☐ **Other:**	

Does your child play video games? ☐ Yes ☐ No
If Yes, How many hours and what kind of games: _____
_____
Please describe other screen time and frequency: _____
_____
Please list your child's strengths: _____
_____
Please list your child's weaknesses: _____
_____
What are your goals for therapy? _____
_____

Please let us know your child's favorite things:
Food: _____ Drink: _____
Toy: _____ Game: _____
Activity: _____ Candy: _____
Other Favorites: _____

Please describe your child's daily routine, including bedtime routine and sleep schedule: ___
_____
_____
_____
_____

On a scale of 1 to 5, how well does your child function in the following areas? (Circle One)
1=Completely dependent on others. 2=Needs help 75% of the time. 3=Needs help 50% of the time.
4=Needs help 25% of the time. 5=Completely independent, no difficulties in this area.

Self Care:		**Rating**
Dressing Upper Body	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Dressing Lower Body	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Toileting	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Eating with a Spoon	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Eating with a Fork	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Eating with a Knife	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Grooming (Hair)		1 2 3 4 5 Not Applicable
Grooming (Bathing)		1 2 3 4 5 Not Applicable
Grooming (Teeth)		1 2 3 4 5 Not Applicable
Feeding:		
Breast/Bottle Feeding	Started at _____months/_____yrs	Easy Difficult
Eating Pureed foods	Started at _____months/_____yrs	Easy Difficult
Eating Solid foods	Started at _____months/_____yrs	Easy Difficult
Drinking from a cup	Started at _____months/_____yrs	Easy Difficult
Drinking with a straw	Started at _____months/_____yrs	Easy Difficult
Communication:		
Babbling	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
First Word	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Saying Sentences	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Following verbal directions		1 2 3 4 5 Not Applicable
Motor:		
Handwriting		1 2 3 4 5 Not Applicable
Cutting with scissors		1 2 3 4 5 Not Applicable
Rolling	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Sitting on own	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Crawling	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Pulling to stand	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Standing	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Walking	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Running	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Jumping (two feet)	Started at _____months/_____yrs	1 2 3 4 5 Not Applicable
Keeping up with peers		1 2 3 4 5 Not Applicable
Eye-Hand Coordination		1 2 3 4 5 Not Applicable
Catching ball		1 2 3 4 5 Not Applicable
Throwing ball		1 2 3 4 5 Not Applicable
Balance		1 2 3 4 5 Not Applicable
Walking up stairs		1 2 3 4 5 Not Applicable
Walking down stairs		1 2 3 4 5 Not Applicable
Moving across uneven ground		1 2 3 4 5 Not Applicable
Play:		
Playing with familiar peers		1 2 3 4 5 Not Applicable
Playing with unfamiliar peers		1 2 3 4 5 Not Applicable
Entertaining self		1 2 3 4 5 Not Applicable
Maintaining attention to tasks		1 2 3 4 5 Not Applicable
Frustration tolerance		1 2 3 4 5 Not Applicable
Safety awareness		1 2 3 4 5 Not Applicable

Building Blocks Occupational, Physical, and Speech Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701-3537 Ph: (907) 374-4911 Fax: (907) 374-4934

Patient Name: _____

As a parent/guardian, please initial each box to show that you have read and understand the information below:

☐ Evaluations are typically scheduled for 2 hours, but it may not take the full 2 hours.

☐ If the evaluation shows that your child needs therapy, sessions will be scheduled for one-hour sessions for a set schedule each week. Your evaluating therapist will determine how many times each week that your child will need to attend sessions, and they will talk to you about this frequency at the end of your child's evaluation session.

☐ It is extremely important that your child attends the full number of sessions each week for your child to make good progress.

☐ The therapist will likely also give you things to work on at home on the days that your child is not at therapy. These activities will be extremely important in helping your child continue to make progress.

☐ We really need to emphasize the importance of attending all of your appointments each week

☐ We do require that you schedule other medical and/or family appointments at different times than your therapy schedule to ensure that your child will receive the therapy that they need.

☐ **<u>If you are not able to do a regular schedule for treatment sessions</u>**, then please let our office know right away. We can explore other options for your child's therapy sessions such as:

- Calling each week to see what openings we have available that week, but if you need to call each week, we would still need your child to attend the number of sessions that your therapist recommended.
- Or you could be on a cancellation wait list that we could call you when we have cancellations to see if you can attend at that time. This option requires that you are flexible in your schedule because some days may be at 9:00am and other days at 4:00pm, or anywhere in between.
- You can participate in some sessions over telehealth if it is appropriate
- If this is not a good time for their family to start therapy, then they can choose to remain on the waitlist, and we will call them when we do the next round of evaluations

Building Blocks Occupational, Physical, and Speech Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

Welcome to Building Blocks' Live Video Online Therapy Services! The quality and care we take in our live video services is the same as those that we provide in person. This is simply a different way of delivering the services.

We are using thera-LINK, a secure video service for online sessions. We use thera-LINK because it's very user friendly. That said, there are some very important things you'll need to know in order to avoid the potential frustration of not being able to connect at our scheduled appointment time.

We've added you as a client on thera-LINK. **The system automatically generated an email that contains a link that you MUST click on to accept the invitation and join thera-LINK**. When you click the link, you'll create your password and type in some other information. That first email might go to your junk/spam/clutter file, so go ahead and look for that at your earliest convenience.

As soon as you have your log in information, you can log into thera-LINK. The dashboard will list your appointment details after we schedule it with a green join button that is available 2 hours prior to your appointment. The system also has a menu on the left called support, which can further answer any questions.

If you're using a PC, Mac, or Android device, **please use Chrome, Firefox, or Safari version 12.2 or greater**. If you are using an iPhone or iPad, use **Safari 12.2 or higher**.

Rebooting your computer before a session is a good idea especially if you've used other applications during the day that utilize your speakers/camera/microphone - not required but it's often helpful with some systems.

Once you've logged in, you can click on the settings menu to upload a picture of yourself if you'd like. thera-LINK auto detects your time zone and your appointments will be displayed accordingly.

Once you have clicked the button to join our session, you will be placed in our "waiting room". You will remain there until your therapist joins the session. We are attaching a checklist to this letter to make sure that you have everything ready for your session.

Finally, keep in mind that when using thera-LINK, the more bandwidth you have available, the better your connection will be. Therefore, if you're planning on using a phone or tablet, connecting to Wi-Fi will vastly improve the session.

Disconnections may occur. If we get disconnected, we will restart the session on our side. If you don't see your therapist in a few minutes, go back to the Dashboard and click the green join button again. We will call you if more than 5 minutes have elapsed.

We look forward to providing services using this technology. If you have any questions, feel free to call us.

Building Blocks Occupational, Physical, and Speech Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

INFORMED CONSENT ADDENDUM FOR ONLINE THERAPY

Patient Name _____ Date of Birth _____
Primary Phone Number _____ Alternate Phone Number _____

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with documents that are required of all clients prior to starting therapy services at Building Blocks. Online therapy or teletherapy is one delivery method of therapy services that Building Blocks offers.

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and a Building Blocks device to connect us securely.

thera-LINK uses encrypted data streams (AES-256) for our video sessions. Any data that is stored outside of our video session on the thera-LINK platform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session, using the phone numbers listed above.

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

Consent to Treatment

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Building Blocks Occupational Therapy, Building Blocks Physical Therapy, and Building Blocks Speech Therapy (also referred to as “Building Blocks”) to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Building Blocks at any time. I understand Building Blocks will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____
Patient/Client Signature

_____
Parent, Guardian or Legal Representative Signature
(if minor or needed otherwise)

_____
Date

Building Blocks Occupational, Physical, and Speech Language Therapy
398 Hamilton Ave, Fairbanks, AK 99701 Ph: (907) 374-4911 Fax: (907) 374-4934

Patient Portal

Our clinic utilizes a patient portal through Fusion Web Clinic for access to your child's documents, such as Evaluation Reports, Progress Notes, Re-Assessments, and Discharge Summaries. You can also view your upcoming appointments.

Patient Name	
Date of Birth	
Email Address(es) to have access to Portal	

An email will be sent to you. Please open the email and set up your user account for access to your child's documents. All you will need to do is create a password for your account.

Paper copies of documents are available upon request. If you are not able to access the portal and require paper copies of the documents, please indicate that here or call our front office to opt out of the portal:

☐ I do not have access to use the patient portal and require paper copies of documents