New Client Intake Questionnaire and Consent to Treat

The purpose of the information you provide is to better assist you in progress towards your treatment goals and general wellbeing. Please answer the following questions as completely as possible. Thank you.

Client Name:_____ Date:_____

Birth date:_____ Referred by_____

Email:_____Phone Number:_____

May we leave a voice mail/text on your phone? Yes/No

Address:_____

Emergency Contact Name/Phone:_____

Relation of Contact to Client:_____

Place of employment:_____Primary/Referring Physician:_____

Insurance plan: _____

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Are you pregnant: Y / N

Please list or provide a list of all medications that may be relevant to the treatment process. For any changes in medication use/management you **MUST** consult your doctor(s): _____

_____

_____

_____

Please list the **name** and **contact information** of any health care practitioners you see or have seen for this problem (i.e. Medical Doctors, Osteopaths, Naturopaths, PTs, OTs, SLPs, Acupuncturists, Mental Health practitioners, Herbalists, Massage Therapists, etc):_____

_____

_____

_____

I give Nikole Willman permission to speak to the above listed professionals regarding my care, progress and treatment plan.

(Sign to consent)_____

Have you had or currently have any of the following conditions: (circle all that apply)

Increased cranial pressure	Cerebrospinal fluid leak
Acute stroke	Spina Bifida
Cerebral aneurysm	Arnold Chiari Malformation
Hemorrhage	Recent skull fracture

Herniated medulla oblongata Concussion

Please describe your current condition/injury:_____
_____
_____
_____
_____
_____
_____

When did this problem begin?

Does anything make this problem better/ worse? _____
_____
_____
_____
_____

What are your goals for treatment? What would you like to be able to do when you are done with therapy?

What do you consider to be your health strengths?

What do you consider to be your health challenges?

List the frequency, duration, and types of exercise you normally do:

Do you have any difficulties with sleep or with waking up feeling rested? If so, please detail:

Do you have any difficulties completing normal daily tasks (i.e. dressing, bathing, cooking, cleaning, work, etc)? If so, please detail:

How stressful do you feel your life is currently? Please describe the stressors in your life:

What is your occupation?

How long have you worked at this occupation?

Do you work full time or part time ?

What hobbies do you enjoy? Frequency of hobbies?

What life roles are important to you, currently? What roles are limited at this time by your current condition? (i.e. parent, employee, volunteer, artist, etc):

Do you currently use Tobacco or Alcohol? If so, in what form? Frequency? :

Health History

(Please describe your health history as completely as possible, using additional sheets of paper, as needed)

Please list all surgeries (including eye and oral surgery) you have had: (Please include what type of surgery you had and date of surgery, how successful you feel the surgery was, and if you are aware of any continuing effects from the surgery and, if so, what?)

Describe all significant injuries including hard falls, broken bones, whiplash injury, concussions/head trauma, spinal injuries, crush injuries, burns, visual/eye trauma, cuts, piercing injuries, soft tissue injuries, etc:

Describe all significant illnesses you have had along with dates, treatment, and outcome. This includes infectious, metabolic, inherited, mental/emotional, or other:

Do you have numbness or tingling?

Do you require any type of assistive device or techniques to complete daily tasks (i.e. walker, shower chair, reacher, memory aides, etc)?:

Please describe any known birth trauma you may have experienced :

For Women:

Please describe your history of pregnancies and child births. For each event, please list approximate dates as well as the course of the event and outcome:

Are you currently pregnant? If so, when is your due date?

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential. I hereby give my consent to receive Occupational Therapy, Craniosacral and/or other bodywork or treatment from Nikole Willman, OTR/L, and Bluffton Craniosacral & Tongue Tie Therapy, LLC and I acknowledge and agree that I am doing so at my own risk. My health and safety with respect to such services are my sole responsibility. I further understand that for any changes in medications or management of medical conditions that I must consult my physician. In exchange for receiving services I (the client), for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge and hold harmless Nikole Willman, OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC from any and all liability for any and all injuries, including death, damages or claims relating to or resulting from my receipt of the services, now or in the future, foreseen or unforeseen. Further, I will indemnify and hold Nikole Willman, OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC harmless from and against any and all claims, rights, damages, liabilities, losses, costs and expenses (including reasonable attorneys' fees) arising from or in connection with any injuries to other persons or damage to property caused by or attributed to me. Further, I will not hold liable Nikole Willman, OTR/L or Bluffton Craniosacral & Tongue Tie Therapy, LLC for any injury or undesirable effect incurred on the premises or in the driveway or entry including, but not limited to, ice, uneven surfaces, stairs, carpet, toys, or faulty equipment such as treatment table or seating.

I acknowledge that I have read and understand the release and indemnification provisions set forth in the preceding paragraph, and agree to such terms.

Client Signature_____Date_____

Bluffton Craniosacral & Tongue Tie Therapy, LLC

Thank you for choosing Bluffton Craniosacral & Tongue Tie Therapy, LLC. The services you seek imply an obligation on your part to ensure payment is made in full for services received. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expense please advise us in advance.

Payment is due at the time services are rendered. Your time of service payment is $175 (initial)/ $125 (follow ups).

* **I understand that I am responsible for charges billed directly to me as a result of "No Shows" or last minute (*less than 24 hour notice*) cancellation ($125.00).**

If you have any questions please contact our office for assistance.

Patient Name:_____

Parent Name (if minor): _____

Parent Signature (if minor): _____

Date:_____

Financial Policy

Thank you for choosing Bluffton Craniosacral & Tongue Tie Therapy, LLC to meet your Occupational Therapy (OT) needs. Your clear understanding of the financial policy is important to our professional relationship. **Payment for service is due and payable at the time of service**. I fully understand that I am directly and fully responsible to Nikole Willman OTR/L for service rendered to me and that this agreement is made solely for Nikole Willman OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC additional protection and in consideration of the practitioners awaiting payment. Billing receipts can be provided upon request and can be submitted by you, the client, to your insurance for potential reimbursement. Please check with your insurance provider about the number of OT treatment sessions allowed per year and about their reimbursement policies for out of network providers.

I understand that Bluffton Craniosacral & Tongue Tie Therapy, LLC does not participate with any insurance companies and does not provide progress reports that could be requested for reimbursement. I am fully responsible for payment of service. I further understand that payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I also understand that many insurance companies do not reimburse Craniosacral Therapy services, regardless of diagnosis and medical necessity.

I have read the above and understand I will be responsible for full payment at time of service and submission for reimbursement to my insurance company. I understand that my insurance company may not offer reimbursement for services rendered by Bluffton Craniosacral & Tongue Tie Therapy, LLC, an out of network provider, even if coverage exists and documentation is provided. I understand that insurance issues will be the responsibility of the client, and Nikole Willman, OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC will not respond to insurance company requests for additional information. Any additional information, including reports, correspondence or consultation with other providers by Nikole Willman, OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC will be subject to an hourly consult fee of $125 per hour to be paid by the client prior to release of information.

Client Signature:_____ **Date:**_____

Client Signature (if client is a minor)_____**Date:**_____

Client Consent/Release of Information

*I authorize Nikole Willman, OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC to provide Occupational Therapy evaluation and treatment as deemed appropriate by the Occupational Therapist or Physician.

* **I understand that I am responsible for charges billed directly to me as a result of "No Shows" or last minute (*less than 24 hour notice*) cancellation ($150.00).**

*I understand I am financially responsible to pay Bluffton Craniosacral & Tongue Tie Therapy, LLC if my insurance company fails to reimburse for therapy provided.

*I authorize that the release of information regarding my injury/illness/accident/treatment plan can be provided to my physician(s) and/or other licensed health care providers for the purposes of my treatment.

*I authorize that other health care professionals are allowed to provide information regarding my injury/illness/accident/treatment plan to Nikole Willman, OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC for purpose of my treatment.

*I authorize Nikole Willman, OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC to release information to my insurance company for the purposes of billing and payment.

*I understand that as a health care provider, Nikole Willman OTR/L and Bluffton Craniosacral & Tongue Tie Therapy, LLC is required by law to maintain and protect the confidentiality of my health information. I must give her written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, payment from third-party payers, quality assurance activities, public health, research, law enforcement activities, and consultation with other health care professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining my consent. Please note that we may contact you for appointment reminders, seasonal greetings, announcements and to inform you about our practice.

Client (or Responsible Party) Signature:_____**Date:**_____

Bluffton Craniosacral & Tongue Tie Therapy, LLC

HIPPA NOTICE PRIVACY PRACTICES

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

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the practice authorized to remove the files from the Practice's office.
NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – in order to provide you with the health care you require, the Practice will provide your PHI to those healthcare professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

(b) Payment- In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written consent from you, in the following additional instances:

(a) De-identified information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard you PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations –

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your consent as soon as possible; or

(ii) To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – if, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such a disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was a result of criminal conduct.

(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

Your health care provider or staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.

You have the right to refuse us authorization to contact you to provide you appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Sign-in-log

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in sheets are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and if so, disclosure only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with written Authorization.

Your Right To Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, your must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with an emergency treatment.

You Have a Right to

Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The practice will accommodate all reasonable requests.
Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice.

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, (202) 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE REQUIREMENTS

1. The Practice:

· Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal

duties and privacy practices with respect to your PHI.

· Is required to abide by the terms of this Privacy Notice.

· Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire

PHI that it maintains.

· Will distribute any revised Privacy Notice to your prior to implementation.

· Will not retaliate against you for filing a complaint.

Patient Signature:_____