Last Name: _____ First Name: _____
Middle Name_____
DOB: _____ Male _____ female _____
Mother's Name _____ Father's Name _____
Child's School _____
Address _____ City _____State_____
Zip _____County _____ Social Security # _____
Phone _____ Cell _____ Work _____
Email address
_____Fax_____
Referred by:
_____
Reason referred to agency:
_____
Mothers name: _____
Maiden name:_____
Mother's
occupation:_____
Father's name: _____
Father's Occupation _____
Delivery: Normal_____ Complication _____ Preterm _____
Does the patient have need for Handicap access? _____Y _____ N
If yes, what accommodations are needed?
_____
Is there any current or past substance abuse, suicide attempts, or alcohol in the home? If yes please explain:
_____
Are the parents of the child married, separated, or divorced?
_____
If separated or divorced, what are the custody arrangements:
_____
Any current changes in the home: (birth, divorce, abuse etc.)
_____
Any situation in your home, school, neighborhood or extended family that you may feel can effect or impact treatment?
_____
_____
_____

Is your family and or extended family available to help out with treatment plan?

_____

Does your family have any cultural, spiritual or religious beliefs that influence the child?

_____

Do you have the support within your community for your needs? (Support groups, social services, school based services

_____

_____

_____

Any legal issue pending for patient or family member?

_____

If yes, with whom?

_____

Allergies_____

_____

Medical Diagnosis

_____

Who gave diagnosis?_____

Date of diagnosis:

_____

Medications _____ as of_____

_____

Prescribed

by:_____

Developmental History

_____

_____

_____

_____

_____

_____

_____

_____

Has your child have any significant physical medical conditions like excessive ear infections, whooping cough, chicken pox, measles etc.

_____

If yes please state for how long and how old was the child at the time.

_____

Are there any mental functions that appear in child behaviors such as anxiety, mood swings, impulse control, memory loss, attention, concentration etc.?

_____

_____

_____

Please list any current or past history of Mental or physical illness in any of the immediate and extended family.

Mother's family history:

_____

_____

_____

_____

Father's family history:

_____

_____

_____

_____

Siblings:

_____

_____

_____

_____

_____

List siblings and ages:

_____

_____

_____

_____

_____

Primary Care Physician _____ Phone _____

May we contact the PCP? _____ YES _____ NO

Insurance Co: _____Policy # _____

Name of insured _____ Group _____

Insured DOB: _____

Emergency Contact Information:

1. Name _____ Relationship: _____

Phone: _____

2. Name _____ Relationship: _____
Phone: _____

Primary Concerns/Current Behaviors/ Symptoms. Why are you currently seeking therapy?

_____
_____
_____
_____

Secondary Concerns:

_____
_____
_____
_____
_____

History of Previous medical and or therapy Treatment:

_____
_____
_____
_____
_____
_____

Please list other service providers involved in your child's care:

_____
_____
_____

Does Build N Care LLC have the right to communicate with the above provider(s)?
Y _____N_____

_____
_____

What are you child's strengths?

_____
_____

What are your child's likes and dislikes?

_____
_____

Is your child or family involved with any community organizations?

_____

_____

Is there any additional information you feel would be able to help the treatment of your child?

_____
_____
_____

Please submit all past medical record, evaluations and or IEP's for us to provide a complete comprehensive assessment.

I acknowledge that if insurance doesn't pay I am responsible for payment of services rendered.

Parent signature: _____ Date:_____

I allow Buildncare therapist to work with my child and do not hold them liable for anything.

I understand that the staff at Buildncare LLC will compose the most appropriate objectives and goals for my child.

I, the parent, understand that I must be available in the home to provide support for the provider. Providers do not change diapers or clean wounds. In case of any spills of bodily fluid, such as blood, urine and the like, the parent must take over.

CANCELLATION POLICY: In case of a true emergency or your child is not well, please cancel your session at least 24 hours in advance. If there are frequent cancellations please understand that a therapist may chosse not to be on your child's team.

Please note; all patient's documents are processed and stored electronically and patient will be required to sign electronically at the end of every month.
Patient is responsible to notify clinician of any infectious diseases, illness, or chemical dependencies may be present in the home at the time clinician would be providing services.
I allow Build N Care staff to take my child out into the world for "life skills" and do not hold them or the clinician liable YES _____ NO_____
I have read and understand Build N Care LLC policies and procedures:
Parent Signature_____
Print Name _____ _____ Date_____

Team Information

To enhance your child's program it is optional to fill out the information below to maximize the communication between the staff that works with your child.

NAME _____

	Phone	E-mail
Teacher		
Speech Therapist		
Occupational Therapist		
Physical Therapist		
Parents		
School Personnel		

Informed Consent for Patient:

I hereby request and consent the performance of therapy and related services for me and for whom I am responsible by BuildNCare LLC.

I understand that, as in the practice of medicine and therapy there are some risks and benefits to treatment, including but not limited to injury, trauma, regression and the like. I do not expect Buildncare to anticipate and explain all risks and complications. I understand I have the right to refuse or terminate services at my will.

I understand that I and family members have a right to understand and be actively involved in the treatment plan.

I wish to rely on the professionals at BuildnCare LLC. To exercise their judgment during the course of therapy and procure which the staff feels at the time, based on the facts then known, and is in my best interest.

I have read the above consent. By signing below I agree to the above and allow Buildncare LLC to perform therapy services. I intend this consent form to cover the entire course of treatment for my present condition and for future conditions for which I seek treatment.

Patients Name _____ Date _____

Patient or Guardian Name _____ Date _____

Documentation and Signing:

I hereby acknowledge that as a parent of a child in Buildncare LLC, I will log onto Buildncare web-based program, “members.centralreach.com”, one time monthly in order to review my child’s records and sign off on all documentation. I understand that I will be given a confidential username and password from the office that I will be able to use to access those records. In the event that I do not have regular internet access, I acknowledge that I will be required to come down to the Buildncare LLC main office in order to sign off on that documentation.

Patients Name _____ Date _____

Parent or Guardian Name _____ Date _____

Build N Care Therapy LLC
NOTICE OF PRIVACY PRACTICES

Effective Date: December 3, 2009. **Revision Date:**

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

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care generated by Build N Care Therapy, LLC.

Privacy Contact. If you have any questions about this policy or your rights contact Build N Care Therapy, LLC at (844) 492-8453.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Build N Care Therapy, LLC. This includes for:

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside Build N Care Therapy,LLC. That we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS

You have the following rights under State and federal law:

Copy of Record. You are entitled to inspect the personal health record BUild N Care Therapy, LLC has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing to Build N Care Therapy, LLC is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Director who will consult with the staff involved in your care to determine if the request can be granted.

.Contacting you. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the Director and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after December 3, 2009, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our Privacy Officer in writing at our office further Information. You

also may complain to the Secretary of Health and Human Services if you believe Build N Care Therapy, LLC has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. Build N Care Therapy, LLC reserves the right to change its Privacy Policy based on the needs of Practice Name and changes in state and federal law.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of BUild N Care Therapy, LLC's health care operations. The Notice of Privacy Practices also describes my rights and Build N Care Therapy, LLC's duties with respect to my protected health information

Build N Care Therapy, LLC. Reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment,

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Authorization for Release of Information

Member's Name #	Birth Date	□ Members ID □ SSN □ Chart
Street Address	City	Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alchohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter 1, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS- related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I also understand that my health plan may not condition treatment, payment, enrollment , or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying B in writing, but if I do, it will not have any effect on any actions B took before it received the revocation.

I hereby authorize B to (check all that apply):

□Exchange with □Release to □Obtain from the parties I have indicated below

I hereby authorize B to exchange/ release/ obtain information both verbally and in writing with:

Insurance Provider: _____

Name of minor: _____

Name	Signature	Date