Dear Parents/Guardians:

The staff here at Sierra Pediatrics Therapy Clinic would like to welcome you to our family. It is important that you are aware of our billing and cancellation policies. Please take a few minutes to read and sign this document, acknowledging your responsibilities.

1. The initial evaluation is $250.00 and the hourly rate for therapy is $125.00 an hour. You are ultimately responsible for the bill incurred from Sierra Pediatric Therapy Clinic for treatment. Copays are due at time of service. **Sierra Pediatric Therapy Clinic bills your primary insurance as a courtesy to you – we do not bill your secondary insurance. The insurance world has changed so much and policies vary, it is your responsibility to fully understand your insurance policy. It is <u>not</u> SPTC's responsibility to verify coverage, if your deductible has been met or authorization for treatment.**

2. It is your responsibility to make sure that SPTC has an updated prescription for therapy from your physician. STPC requires 14-day notice prior to expiration of benefits if a progress report is needed to authorize more visits.

3. We do accept Visa and MasterCard for your convenience.

4. Cancellation of a scheduled appointment requires 24-hr. notice. Your insurance company does not pay for cancelled appointments. Cancelled appointments that have not been given 24-hr. notice as well as No Shows will become the responsibility of the parent for up to and including the full amount.

5. For more information about Sierra Pediatric Therapy Clinic you may visit our website at sierrapediatrics.com.

6. If you have any billing questions please contact our office at (916) 791-2747 or e-mail sierrapeds2002@yahoo.com.

   Please keep this copy of our policies for your records. Sign the following page regarding this agreement and return to the Sierra Pediatric Therapy Clinic. You will be contacted for an appointment upon receipt of this information.

I have read and agree to the above policies. I understand that I am ultimately responsible for any therapy services performed. I understand these documents must be returned before my appointment.

_____
(Please print name)

_____ _____
(Signature) (Date)

Prescription Requirement

Please provide us with a prescription from your child's physician at your first appointment. It is a California state law for our therapists to have a prescription on file in order to treat our patients.

Your child's prescription MUST include:

- Your child's name
- Child's date of birth
- Child's diagnosis
- Type of therapy to receive i.e. Speech, Occupational or Physical Therapy
- Doctor's signature

Thank you,
Sierra Pediatric Therapy Clinic Staff

Patient Easy Pay Consent

I authorize Sierra Pediatric Therapy Clinic to charge my credit card for the balance not paid by my insurance company.

Not to exceed $_____

_____ Annually

_____ Semi-monthly

_____ Weekly

_____ Per Visit

Date(s) of Service: ____/____/____ to ____/____/____

I assign my insurance benefits to the provider listed above. I understand that this form is valid for the entire treatment plan unless I cancel the authorization through written notice to the health care provider.

_____ _____

Cardholder Signature Date

Patient Name
Cardholder Name
Cardholder Address
City State Zip
Credit Card Type _____Visa _____ MasterCard
Credit Card # Exp. Date

Expectations

Whether your child is entering therapy for the first time or your child has participated in therapy in the past, you are making a serious commitment to enrich your child's life experiences. Consequently it is important to us that you know that we respect you as a parent and wish to give you and your child the best experience possible. It is important to us that you understand we believe the most critical component in your child's treatment program is you. Your commitment must go beyond bringing your child for therapy; it requires your active participation at the clinic and home.

What do we expect from you?

We understand that time is extremely valuable. In order to achieve the most from each treatment session your effort for the remaining 167 hours is part of keeping the value of the time beneficial.

- Therapy and function should be the same.
- Therapy incorporated into daily life becomes routine.
- Consistency and repetition builds strength, control and endurance, increasing success.

You will be expected to follow through with 2 to 4 simple exercises or activities daily. We will work with you to make this part of your daily routine or you can be creative.

Your child is an essential member of the team. We believe that all children must be included in this process. This role will vary according to the child's age and needs.

As an active participant in this process, we encourage you, the parent, to communicate with us regularly. It is extremely important that we know what is important to you, your child and your family. Goals set for your child will be achieved by:

- Incorporating therapeutic activities into everyday routine and events
- Open communication/relationship expressing your needs and plans

What can you expect from us?

Your goals and plans will guide our intervention, education/training/strategies for meeting these life expectations.

We will work diligently at each treatment session to produce changes within the treatment hour to meet or exceed the goals we have all established.

We will provide you with exercises and activities to be done daily at home, incorporating them into daily functions as is possible.

We will communicate changes and concerns we have for your child.

We will work with other clinicians/agencies your child may require in a manner most appropriate for you and your child.

(Parents)_____Date_____

Sierra Pediatric Therapy Clinic

New Patient History Form

Child's Name: _____ Date: _____

Date of Birth: _____Child's Diagnosis: _____

Dad's Name: _____ Mom's Name: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Email: _____

Dad Employer: _____

Dad Work Phone: _____ Dad Cell Phone: _____

Mom Employer: _____

Mom Work Phone: _____ Mom Cell Phone: _____

Physician History:

Doctor/Pediatrician: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Neurologist: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Other Programs/previous therapy (Please be accurate giving names of programs, therapists, teachers, dates, etc.) _____

_____

_____

_____

Other Children at home and ages: _____

Referred to SPTC by: _____

Authorization for Release of Medical Information

To: _____ From: Sierra Pediatric Therapy Clinic
(Hospital, clinic, physician, other health care provider) 720 Sunrise Avenue, Suite D110
Roseville, CA 95661
Phone: (916) 791-2747
FAX: (916) 791-2189

Address:_____ Phone: ( ) _____

_____ FAX: ( ) _____

Patient name: _____ Date of Birth:_____

Hereby authorizes two-way communication between the parties indicated above which shall include the release of medical records, and / or information pertaining to diagnosis and treatment for the purpose of assessment, evaluation, therapy and utilization review. This authorization will become effective immediately and shall remain in effect until revoked in writing by the patient, or the patient's parent or legal guardian.

The information requested is checked below.
Please check the items and sign below.

_____ Health history

_____ In-patient and out-patient medical records

_____ Laboratory and other procedure reports

_____ Physical examination reports

I release Sierra Pediatric Therapy Clinic and its associates and personnel from any legal liability resulting from the release of this information with the understanding that reasonable professional safeguards regarding this information will be taken. I understand further that I have the right to receive a copy of this authorization upon request.

Signature: _____Date: _____
(Patient) or (Parent or Legal Guardian)

Sierra Pediatric Therapy Clinic

Release Form

I hereby, consent for all purposes to the publication, reproduction and/or use of still photographs, video images or audio recordings of me/my child, with or without the use of my name by Sierra Pediatric Therapy Clinic in all forms, media and in all manners, including promotional, educational, display, editorial and exhibition.

In giving this consent, I release Sierra Pediatric Therapy Clinic from any liability for any violation of any personal or proprietary right I may have in connection with such publication, reproduction or use.

Guardian's Consent

I am the parent/guardian of the minor named below, and have the legal authority to execute the above consent and release. I approve the forgoing and waive any rights on the premises.

Name of minor:_____Date:_____

Signature of Guardian:_____

Address:_____

_____

I am more that eighteen years of age.

Signature:_____Date:_____

Address:_____

_____

720 Sunrise Avenue, Suite D110, Roseville, CA 95661
Phone (916) 791-2747, Fax (916) 791-2189

The responsibility of Sierra Pediatric Therapy Clinic regarding your medical information

HIPAA (Health Insurance Portability and Accountability Act)

- making sure your medical information is protected
- notify you of our legal duties and privacy practices regarding your medical information via this notice
- follow the terms stated in this notice which are currently in effect

How we may legally use your medical information

For treatment We may use medical information about you to provide you with medical treatment or services. We may disclose information about you to doctors, nurses, technicians, students or other health system personnel who are involved in taking care of you in the health system.

For Payment We may use and disclose medical information about you so that the treatment and services you receive at Sierra Pediatric Therapy Clinic may be billed to and payment may be collected from you, and insurance company or a third party.

Health-Care Operations Your medical information may also be used to comply with law and regulation, for contractual obligations, patients' claims, grievances or lawsuits, health-care contracting, legal services, planning and development, and management or administration. We may also disclose information to doctors, medical and other students, and other health system personnel for performance improvement and educational purposes.

Appointment Reminders We may contact you to remind you that you have an appointment.

Treatment alternatives We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Fund-raising activities We may contact you to provide information about Sierra Pediatric Therapy Clinic or Ride to Walk sponsored activities and fund-raising events. We would only use contact information, such as your name, address and phone number.

News-gathering activities We may contact you or your family members to discuss whether or not you want to participate in a media or news story.

Individuals involved in your care or payment for your care We may release medical information to anyone involved in your medical care, e.g., a family member, parent/guardian, a friend or any individual you identify. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your general condition.

As required by law We will disclose medical information about you when required to do so by federal or state law.

Legal proceedings We may disclose medical information to courts, attorneys and court employees in the course of judicial proceedings.

Medical Information About You

You have the right to:

- **Inspect and copy**
- **Request an amendment addendum**

⌦ Please keep this copy for your records

Acknowledgement of Notice: Privacy Practices of the Sierra Pediatric Therapy Clinic

I, _____, verify that I have read and been provided with a notice regarding the privacy practices of the **Sierra Pediatric Therapy Clinic.** I understand my/my son or daughter's rights in compliance with the **Health Insurance Portability & Accountability Act (HIPAA).**

_____
Patient Name

_____
Signature of Patient or Parent/Guardian Date

_____
Print Name Relationship to Patient

_____
Interpreter (if applicable)

⌦ Please sign and return this copy to Sierra Pediatric Therapy Clinic

Sierra Pediatric Therapy Clinic

Medical History

Child's Name: _____

Date of Birth: _____

Name of Birth Hospital: _____

Diagnosis: _____

Please check the column that best describes your child. After each item and category, please write any remarks or comments that you feel may be helpful. Please include child's strengths in comment areas.

Perinatal History/Pregnancy:

	Yes	No	Comments
Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations, hypertension, high blood pressure, toxemia, or any other difficulties?			
Were any drugs or medication taken during pregnancy? Describe.			

Delivery:

	Yes	No	Comments
Was the pregnancy full term?			
Was the pregnancy premature? (give months and weight)			
Was it an unusual delivery?			
Was the labor normal?			
Was the labor abnormal?			
Were forceps used?			
Was medication given during delivery?			

Medical History of Child:

Has your child had any of the following? Please give the dates and indicate whether your child had the illness or was immunized.

	Illness Date	Immunized Date	No	Comments
Meningitis				
Measles				
Chicken Pox				
High Fevers				
Mumps				
Whooping Cough				
Scarlet Fever				
Diabetes				
Lung/Bronchial Difficulties				
Heart Defect				Type_____ Medication_____ _____
Seizures				When?_____ How often?_____ Medication_____ _____
Allergies				_____ _____ _____ _____
Excessive Vomiting				
Tuberculosis				
Physical Injuries				_____ _____ _____ _____ _____

Has your child had an eye evaluation? _____
If yes, by whom? _____
Date _____

Does your child have a vision problem? _____
Eye muscle imbalance? _____

Has your child had a hearing evaluation? _____
Date of Evaluation _____
Does your child have a hearing problem? _____
_____

Does your child have a history of ear infections? _____
If so, what is/was the frequency? _____
Has your child had ear tubes placed? _____

Is your child currently on any medication? (If yes, please list and state reason)

Medication	Reason

Has your child had any of the following examinations? If so, please give the approximate date and the examining person's name and phone number.

Type	Exam Date	Specialist's Name	Phone Number
Most Recent Physical Exam			
Neurology			
Pneumogram			
Psychiatry			
Psychology			
Education			
Speech and Hearing			

Other special examinations:

_____

_____

_____

_____

Newborn History:

Child's birth weight:_____lbs. _____oz.

Were there complications such as:

	Yes	No	Comments
Cyanosis			
Jaundice			
Congenital defects			
Limpness			
Stiffness			
Seizures			
Apnea			
Bradycardia			

Was there a need for:

	Yes	No	Comments
Oxygen/Ventilator			
Transfusions			
Tube feedings			
Surgery			

Were there any feeding difficulties?

_____

_____

_____

_____

Was the child bottle fed?_____

What was the length of infant's stay at the hospital?_____

_____

Apgar scores: 1 min_____5 min_____10 min_____

Sierra Pediatric Therapy Clinic

Developmental History

At what age did your child (please be specific with the age):

Roll over both ways? _____
Sit alone? _____
Held head up (while on stomach)? _____
Belly crawled? _____
Crept on hands and knees? _____
Pulled to stand? _____
Stood alone? _____
Walked? _____
Spoke first word? (What was it?) _____
Spoke first sentence? (What was it?) _____
Drank from cup independently? _____
Used a spoon independently? _____
Feed himself/herself independently? _____

Describe your child as a newborn/infant (mark yes or no):

	Yes	No	Comments
Cried a lot, fussy, irritable			
Non-demanding			
Alert			
Quiet			
Passive			
Active			
Liked being held			
Resisted being held			
Was floppy when held			
Was tense when held			
Had regular sleep patterns			
Had irregular sleep patterns			

Describe your child at present (mark yes or no):

	Yes	No	Comments
Is mostly alert			
Is overly active			
Tires easily			
Talks constantly			
Very impulsive			
Is restless			
Is stubborn			
Is resistant to changes			
Over reacts			
Fights frequently			
Is usually happy			
Has frequent temper tantrums			
Is clumsy			
Has difficulty separating from primary caretaker			
Has nervous habits or tics			
Has short attention span			
Is easily frustrated			
Has unusual fears			
Rocks self frequently			
Has difficulty learning new tasks (i.e., throwing a ball, building blocks)			

Self Care:

Is your child…
bottle fed? (circle one) Yes / No / Sometimes
Type of formula? _____
Amount? _____
How often? _____
Any modifications to nipple required? _____

breast fed? (circle one) Yes / No / Sometimes
Frequency per day? _____

Currently eats…
baby foods? _____
junior foods? _____
mashed table foods? _____
table foods? _____
Objects to certain food textures, taste, etc.
Describe: _____
_____
_____

Feed himself/herself? Please describe any difficulties.
All of the time _____
Most of the time _____
Some of the time _____
Rarely _____

During feedings:

	Yes	No	Comments
Holds bottle independently?			
Eat using fingers?			
Uses spoon?			
Uses fork?			
Drinks from cup independently?			

Bathing: Assistance Required or Independent? _____

Dressing: Assistance Required or Independent? _____

Is child toilet trained?
Age trained:
Bladder _____ Daytime only _____
Bowel _____ Daytime only _____

Sierra Pediatric Therapy Clinic

Sensory History

Auditory

Does your child…	Yes	No	Sometimes	Comments
respond negatively to unexpected or loud voices?				
have difficulty paying attention when there are other noises nearby?				
miss hearing some sounds?				
seem confused as to the direction of sounds?				
seem to enjoy strange noises and/or make loud noises?				
appear to be hard of hearing?				
enjoy music?				
have diagnosed hearing loss?				
wear a hearing aid?				
have difficulty understanding what is said?				

Proprioceptive

Does your child…	Yes	No	Sometimes	Comments
hold his/her hands in strange positions?				
hold his/her body in strange positions?				
have a good ability to manipulate small things?				
have movements that are abrupt and quick in quality?				
have poor ability to move slowly from one position to another?				

Gustatory-Olfactory

Does your child…	Yes	No	Sometimes	Comments
act as though all food tastes the same?				
chew on non-food items?				
have unusual cravings for certain foods?				
dislike food of certain textures?				
explore by smelling?				
discriminate odors?				
react negatively to smell?				
ignore unpleasant odors?				

Tactile

Does your child…	Yes	No	Sometimes	Comments
avoid playing with "messy" things? (i.e., finger paint, paste, mud, sand, etc.)				
dislike having his/her face washed or wiped?				
appear to be irritated by cloth of certain textures?				
object to being touched?				
dislike being touched unexpectedly?				
dislike being cuddled?				
prefer to touch rather than be touched?				
avoid using hands for extended period of time?				
bang his/her head on purpose now or in the past?				
pinch, bite, or otherwise hurt self or others?				
examine objects by putting them into his/her mouth?				
tend to feel pain more or less than others?				
frequently bump or push other children?				
dislike hair washing?				
dislike nail cutting?				

Vestibular

Does your child…	Yes	No	Sometimes	Comments
rock while sitting?				
jump a lot?				
like being tossed in the air?				
have good balance?				
seem fearful of space (i.e., going up and down stairs, riding a teeter-totter, going through small enclosed spaces)?				
like merry-go-rounds?				
spin and whirl more than other children?				
get car sick?				
enjoy being rocked now or as an infant?				
have no fear of moving or falling?				
become irritable during long car rides?				

Visual

Does your child…	Yes	No	Sometimes	Comments
appear to be happier in the dark?				
pick up pictures or objects and look very closely and carefully at them?				
become excited when there is a variety of visual objects?				
squint often?				
wear glasses?				
have difficulty visually following an object tossed or rolled towards him/her?				
have difficulty maintaining eye contact with another person?				
shift his/her head from one side or the other in order to look at something?				
tend to reach too far or not far enough when playing, eating, etc.?				

Sierra Pediatric Therapy Clinic

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Roseville, CA 95661
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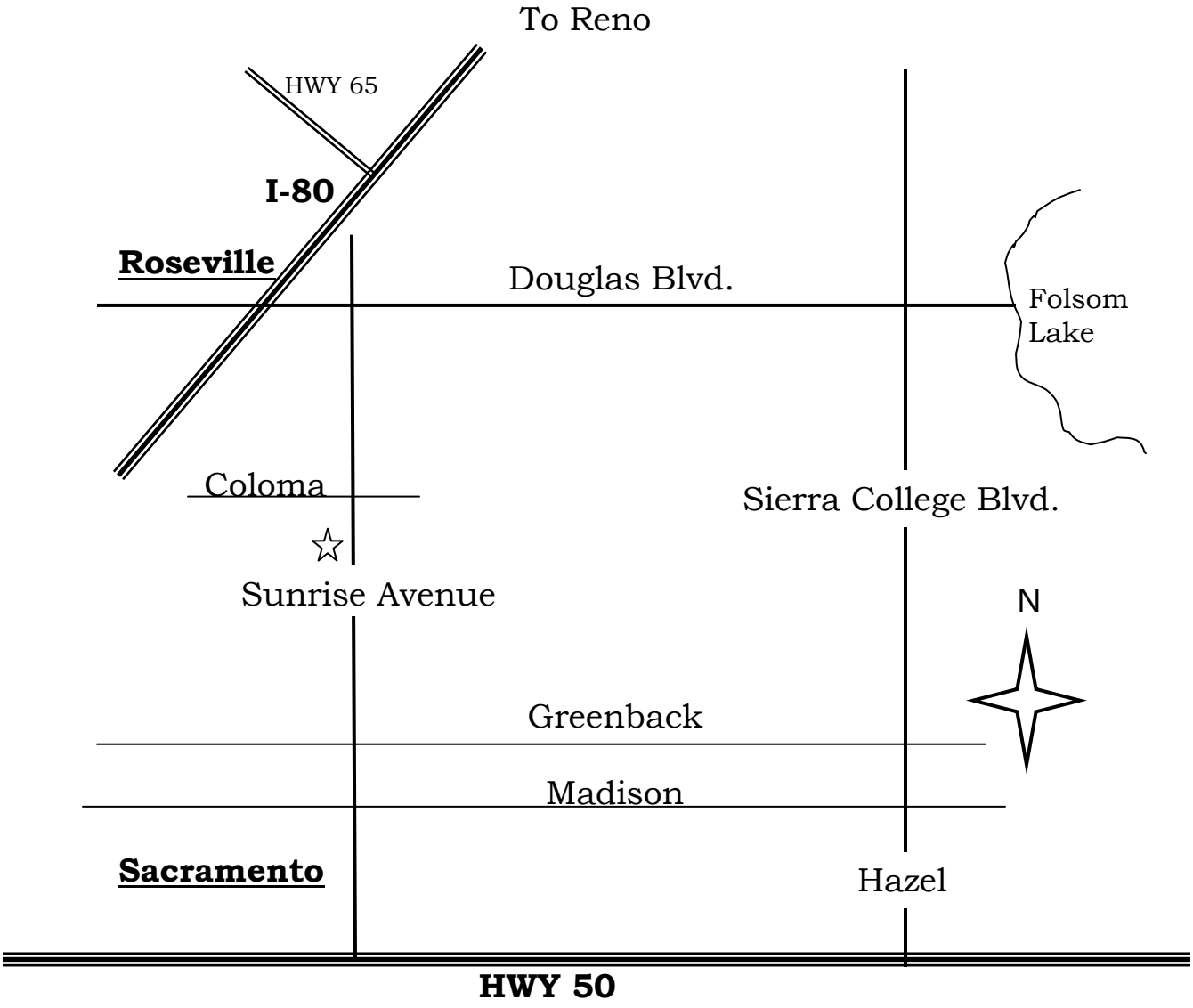

From Sacramento:
Take Interstate 80 East
Exit Douglas Blvd. East
Turn Right on Sunrise Avenue
Go past Coloma, ~75 yards
Make the first left into the parking lot
North side is apartments, South side is businesses