Pediatric Occupational Therapy Center, LLC
66 West Mount Pleasant Ave. Suite 204
Livingston, NJ 07039
973-994-4464

Tax ID # 20-3307969
NPI # 1265644942

Dana Blumberg, OT
Director

WELCOME TO
Positive Steps
Pediatric Occupational Therapy Center, LLC

This letter is designed to answer questions you may have regarding your care here at occupational therapy. We take great pride in our training, knowledge and capabilities and we want you to know that we are dedicated to giving you quality care.

GENERAL OFFICE INFORMATION
We are here Monday through Friday and on Saturdays to assist you with any concerns such as scheduling. We are available to meet with you just about any day. Please do not hesitate to call whenever you have questions or concerns.

Our office hours are 6 days a week, Monday through Thursday from 8:00am-6:30pm, Fridays 12:00pm-5:00pm as well as Saturday Mornings. We try to keep your scheduled appointment time within a few minutes. We believe strongly in the value of your time and will do my best to keep you from having to wait.

The telephone is covered at all times, either by Emily or by voicemail. If we are not available to come to the phone, please leave a message and we will return your call as soon as possible.

ATTENDANCE
Therapy is a "building" process. Consistency of attendance is imperative. Excessive cancellations will result in our request to change your standing appointment.

WELLNESS
Please help us promote a healthy environment for all of our clients. Sick children, siblings or adult clients should stay home. Please respect our request that children, siblings or adult clients be fever free for 24 hours before returning to therapy. This serves the best interest for wellness for all of us.

CANCELLATION POLICY
There will be no charge for therapy if the cancellation is made the day before the therapy session. Our voicemail will record information whenever we are not available to answer the telephone. If the cancellation is not made at least 24 hours prior to therapy, the regular charge for therapy will be entered on your account. (Your insurance will not cover this charge.) The reason for this policy is that when we receive cancellations early enough, we can schedule other clients during that open time. Without notification of the cancellation, we will lose the opportunity to provide therapy during that time. Same day cancellations due to illness or family emergencies are exceptions.

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FEES AND PAYMENT

Payment is expected at the time of your visit each week. If you are coming here more than once per week, you may pay at the last session of that week. For your convenience we accept MasterCard and Visa.

INSURANCE

We do not participate with any insurance companies. If you have insurance coverage, please understand that this is an agreement between you and your insurance company. You are responsible for the payment of your bill regardless of the status of your insurance claim. We will be glad to support your claim with documentation in order to help expedite your reimbursement.

OBSERVATION OF THERAPY

Observation of therapy is a wonderful opportunity families have. Observation enables you to learn how your child best responds to therapeutic techniques, and how you can apply some techniques during your daily routines or practice sessions at home. You may sit in another room and observe your child. Observation times must be limited in general to once monthly.

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A MESSAGE FROM THE DIRECTOR

The best care is based on a friendly mutual understanding. If any problems or questions arise, please bring them to our attention. Again, thank you for your confidence. We are looking forward to getting to know you!

Dana Blumberg

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Wellness Policy

Should My Child Stay Home?

If you check ANY ONE of these, then PLEASE CALL US to cancel!

	Runny nose that is not controlled, not clear or not from an allergy
	Fever within 24 hours of appointment
	Coughing or sneezing with mucous sprays
	Extreme fatigue
	Discomfort or pain
	Contagious condition, such as conjunctivitis (pink eye) or Coxsackie
	Open sores that cannot be bandaged
	Contagious rash, hives or plantar warts
	Did not attend school today
	An accompanying sibling or adult, who will be in the waiting room, is sick
	Lice (Must be lice FREE for 24 hours in order to attend OT)

PLEASE, help us promote a healthy environment for all of our clients, their families and our staff.

PLEASE, keep sick children, siblings or adult caregivers home, where they can rest and heal.

PLEASE, understand that we have a wellness policy to protect you and everyone who visits our center.

PLEASE, call us to cancel 24 hours before your appointment when possible.

PLEASE, ask!! If you're not sure if you should come in or stay home, call us. We'll talk it over with you and help you decide.

PLEASE, see your occupational therapist to discuss any questions regarding our wellness policy.

If it becomes apparent during a therapy session that your child has any of the symptoms listed above, <u>we</u> will end the session and send you home. You will be responsible for payment of the session.

THANK YOU!

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DATE ________________________________

AUTHORIZATION TO RELEASE INFORMATION

I authorize Positive Steps to discuss/release diagnostic information, plan of treatment, goals, and progress reports pertaining to _______________________________________ to the following physicians, therapists, schools or insurance companies:

Name: ___________________________________ Phone: _________________________

Address: ____

Name: ___________________________________ Phone: _________________________

Address: ____

Name: __________________________________ Phone: _________________________

Address: ____

Name: __________________________________ Phone: _________________________

Address: ____

Name: __________________________________ Phone: _________________________

Address: ____

____
Signature/Relationship to Client

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CAREGIVER CONSENT

Please provide the contact information for any caregivers (other than yourself) that may bring your child to therapy. By signing this consent, you allow us to contact them regarding appointments and scheduling.

Name: ______________________________________ **Phone:** ___________________________

Email Address: ____

Name: ______________________________________ **Phone:** ___________________________

Email Address: ____

Name: ______________________________________ **Phone:** ___________________________

Email Address: ____

Name: ______________________________________ **Phone:** ___________________________

Email Address: ____

Name: ______________________________________ **Phone:** ___________________________

Email Address: ____

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CANCELLATION AND PAYMENT POLICY

As of January 2016

Client Name: ______________________________________

Consistency and reliability of appointments is extremely important. In an effort to accommodate you and your child's schedules as well as the staff of Positive Steps, we ask that you please review and adhere to our policy.

CANCELLATION POLICY: WE MUST BE NOTIFIED IF YOU CANNOT ATTEND YOUR APPOINTMENT. All appointments that cannot be attended must be called in no later than 8:00 am the day of the appointment. The full charge for the appointment that is missed **without notice** or after 8 am the day of the appointment will apply. We recommend that you anticipate traffic situations, deliveries and other events and plan accordingly. These situations will NOT be acceptable reasons for late cancellations or "no shows." Please review attached Wellness Policy for illness related cancellations; all other situations will be assessed by the director.

The number to call to cancel an appointment is 973-994-4464. Our voicemail will record information whenever we are unable to speak to you personally or the office is closed.

PAYMENT POLICY:
Payment is due in full at the time of each session. We accept all major credit cards **(except American Express)** as well as personal checks. If an appointment is cancelled outside of the cancellation policy, payment for the missed session will be charged to the credit card on file or due at the next scheduled appointment.

INSURANCE:
We do not participate with any insurance companies. If you have insurance coverage, please understand that this is an agreement between you and your insurance company. You are responsible for the payment of your bill regardless of the status of your insurance claim. We will be glad to support your claim with documentation in order to help expedite your reimbursement.

The Staff of Positive Steps appreciates your cooperation. Thank you

________________________________ ______________

Signature of responsible party **Date**

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ADDITIONAL SERVICES

At Positive Steps we feel that it is imperative that we speak to other professionals involved with each child, as well as provide home programs and sensory diets, with no additional charge.

There is a $75 fee for all progress reports, 504 letters, etc...If a school observation is necessary, there is a $160 charge per hour. These fees are not covered by your insurance.

In addition, we offer private weekly school sessions. This treatment requires permission from the school to perform our services on their property. A 45 minute school session is $160.

By signing below, I agree to the above policy

______________________________ ______________

Signature of responsible party **Date**

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CONSENT FOR TREATMENT

Patient Name: ____

I authorize Positive Steps to perform appropriate assessment and treatment procedures in order to achieve mutually agreed upon objectives.

Signature: _____________________________________

Date: ____

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NOTICE OF PRIVACY PRACTICES
This notice is effective on or after April 14, 2003

This notice describes how medical information about you may be used or disclosed and how you can get access to this information.

LEGAL DUTY
This practice is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described here.

USES AND DISCLOSURES OF HEALTH INFORMATION
This practice uses your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. We may also use or disclose your personal health information for public health purposes, audits, emergencies and when required by law.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

We may change our policy at any time. When changes are made a new Notice of Information Practices will be posted in our office and you will receive a new written notice as well.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any times. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a loss of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergence circumstances. We will consider all such requests on a case by case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS
If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of concern. You will not be penalized or otherwise retaliated against for filing a complaint. Such comments or complaints should be sent to the Privacy Officer at the address listed.

You may also complain to the U.S Department of Health and Human Services if you believe we have violated your privacy rights.

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CONTACT PERSON

The following is the name and address of the person you may contact for further information concerning our privacy practices, to request changes of your privacy protection, to access to your records, or for complaints:

Positive Steps
Pediatric Occupational Therapy Center, LLC
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and understand the attached Notice of Patient Information Practices. I understand that the company may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify Positive Steps.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Positive Step's Notice of Patient Information Practices. In doing so, I hereby release Positive Steps from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in the place of the original.

I understand that Positive Steps reserves the right to modify the privacy practices outlines in this notice, and will notify me of such modification as it occurs.

____
Name of Patient (Print)

____
Signature of Patient
Or
Signature of Patient Representative, which is required if the patient is a minor

____
Relationship of Patient Representative

____
Date

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Email Form

Stay up to date on the latest events, activities, helpful links/articles, blog posts, the latest news, and to remind you of your upcoming appointments, we would like to collect your email address. Your email address will be kept confidential and will not be sold to any third party.

If you are interested in communicating with us electronically, please fill out the form below. We are happy to answer any questions you may have.

Also, please note that Positive Steps Pediatric Occupational Therapy Center has a Facebook page. If you are on Facebook, please "like" us!
Thank you!

☐ Yes, please feel free to include my email in your records to be used for Positive Steps communications only.

☐ No, I do not want to be contacted via email.

Name: ____

Email: ____

Phone: ____

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Photography and Videography Consent Form

I hereby grant full permission to Positive Steps Pediatric Occupational Therapy Center to take my child's photograph and/or video for documentation of my child's progression throughout his or her sessions as well as for professional training purposes.

Any photos or videos of your child will only be seen by yourself and/or the staff of Positive Steps Pediatric Occupational Therapy, and will be kept securely in your child's chart.

____

Child's Name

____

Your Name Relationship to Child

____

Signature

____

Date

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CREDIT CARD PAYMENT AGREEMENT

Name of Client:____

I authorize Positive Steps to enter therapy charges for the client named above, using the following credit card. **Please note that we do not accept American Express**:

Name on Card:____

Card#_________________________________ **Expires** ________ **Security Code** _______

Billing Address:

____

____

Zip Code:______________________________

This information will be held in confidence, as per our Privacy Policy, and will only be used for services rendered, with your knowledge and consent. If you choose to fill this form out and keep your card on file, we will bill your card the morning of your appointment. If there is an emergency and you cannot keep your appointment, the transaction will be voided.

____________________	____________________	____________	____________________
Print Your Name	**Relationship to Client**	**Date**	**Signature**