

NEW PATIENT PACKET

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Rocklin, CA 95677
Phone: (916) 415-0119
Fax: (916) 415-0120
Web: www.stepstherapyinc.com**

Confidential Adult History Questionnaire

Name: _____

Address: _____

(City) _____ (State) _____ (Zip) _____

Telephone: _____ Birth Date: _____ Place: _____

Age: _____ Sex: _____

Person or agency that referred you _____

Name: _____ Address: _____

Phone: _____

Reason for referral: _____

Name of person completing this form: _____

Relationship to client: _____

For what purpose has this evaluation been requested? _____

Please describe the patient's current problem and date of onset: _____

MEDICAL INFORMATION

1. Physician(s): _____ Address: _____

2. Phone: _____

3. Current medication and dosages: _____

4. Does the patient have a history of any of the following?

		Onset Date and Current Status	
		Yes	No
Stroke		Yes	No
Aphasia	Yes		No
Other Communication disorder		Yes	No
Right or left sided weakness		Yes	No
Dementia (e.g. Alzheimer's disease)		Yes	No
Learning Disability		Yes	No
Childhood Speech-Language Delays		Yes	No
Memory Impairment		Yes	No
Other Neurological Disease		Yes	No
High blood pressure		Yes	No
Heart condition		Yes	No
Diabetes	Yes		No
Head Injury		Yes	No
Seizure Disorder	Yes		No
Clinical Depression		Yes	No
Psychiatric Problems		Yes	No
Alcohol Abuse/Problems	Yes		No
Other substance abuse		Yes	No
Other major illnesses		Yes	No

5. What is the patient's handedness?
Ambidextrous

Right Left

6. Does the client have any weakness or paralysis?

If yes, describe

7. Does the patient use a cane, walker or wheelchair?

8. Does the patient wear glasses/contacts?

9. Does the patient have any other visual problems (e.g., right or left visual field cut or cataracts)?

10. Does the patient have a hearing loss?

Does the patient wear a hearing aid? If yes, in the right ear left ear both

11. How would you describe the patient's general health?

12. Please list names and address of physicians/hospitals/clinics that may have relevant medical

Is the patient presently working?

Describe the patient's work history (for example, kind of employment and approximate dates).

8. Please describe any hobbies, recreational activities, social/civic groups, religious activities, music and movie interests, volunteer work

9. Patient's mother's name Living Deceased

Patient's father's name Living Deceased

1. Circle the appropriate answer as it applies currently.

Comment where

appropriate.

Attempts to communicate verbally	Yes	No	
Attempts to communicate in writing		Yes	No
Attempts to communicate using gestures	Yes	No	
Uses a device for talking	Yes	No	
Can tell you or his or her name and address	Yes	No	
Can write his or her name and address		Yes	No
Is speech understandable	Yes	No	
Is writing legible		Yes	No
Can communicate in short sentences		Yes	No
Can write in short sentences		Yes	No
Can repeat or copy words verbally	Yes	No	
Is there automatic speech (e.g., "Hello", "Thank You")		Yes	No
Can understand conversational speech		Yes	No
Can read and understand the newspaper		Yes	No
Can follow daily routine without help		Yes	No
Is easily lost		Yes	No
Has swallowing difficulties		Yes	No
Can remember information from day to day	Yes	No	
Can solve safety and interpersonal problems	Yes	No	
Is easily distracted		Yes	No

9. Please write down any additional information you feel will help us in evaluation or treatment decisions.

Cancellation Policy

Steps Therapy, Inc. has a 48 hour notice of cancellation policy. If you cannot attend your appointment, you must provide notice no less than 48 hours prior to your therapy session.

Evaluation Cancellation Policy -

We have reserved two hours of a therapist’s time for the scheduled evaluation, therefore we require at least **48 hours notice** if you need to cancel or reschedule the evaluation. In the event that you do not show up for child’s appointment or provide at least 48 hours notice to cancel or reschedule the appointment, your credit card on file will be charged the full cost of the evaluation, which is \$385.00

Therapy Cancellation Policy –

We have reserved one hour of a therapist’s time for the scheduled appointment, therefore we require at least **48 hours notice** if you need to cancel or reschedule the therapy session. In the event that you do not show up for your scheduled appointment or provide at least 48 hours notice to cancel or reschedule the appointment, your credit/debit card on file will be charged. 1st occurrence - \$25.00, 2nd occurrence - \$50.00, 3rd occurrence - \$75.00

Steps Therapy, Inc. requires that a current debit/credit card be kept on file at all times. Please provide your account information below and provide your current address on file with your banking institution.

At Steps Therapy, Inc. keeping your private financial information secure is one of our most important responsibilities – one that we take very seriously. We hold your information in the utmost confidence and place well-defined limits on its use.

Front

Back

____ - ____ - ____ -

Exp. __/__

Type of Card

-

CVV Code (last 3 numbers)

Current Address on File with Financial Institution:

Conditions of Admission

Authorization and Consent for Treatment

I consent to and grant permission to the employees of Steps Therapy, Inc to render clinical care including evaluations, educational services, and therapy activities/procedures during my receipt of services, and to carry out the orders of the physician, including consultants, associates and assistants of his/her choice. I also acknowledge that Steps Therapy, Inc has not made any guarantee or warranty as to the results of any services or treatments given.

Initials

Authorization for Release of Information

I hereby authorize Steps Therapy, Inc to furnish and release medical information to my private insurance carrier, or other third party payer, as may be required for the determination of benefits payable. Respecting my privacy and anonymity, I understand that my records may be reviewed for statistical purposes. I grant permission for Steps Therapy, Inc to communicate all aspects of my care with the physician(s) whom I have identified.

Initials

Insurance

I understand that co-pays, deductibles, and co-insurance are due at the time of service. If I am unable to provide Steps Therapy, Inc with my current insurance information prior to my child's appointment, I will pay in full for that day's visit. I agree that I am responsible for knowing and understanding my insurance benefits as they relate to therapy services. I understand that the benefits stated by my insurance company are not a guarantee of payment or coverage, and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. I understand that I am fully responsible for all charges for services and/or treatment rendered, and I further agree that all amounts are due upon request and are payable to Steps Therapy, Inc. I will provide Steps Therapy, Inc with a copy of my insurance card each time I receive a new card and/or my insurance information changes. I understand that if my insurance company delays payment or is waiting on additional information from me before they render payment, and the balance is past 60 days, the balance is my responsibility and is due immediately.

Initials

Valuables

I understand that Steps Therapy, Inc does not assume responsibility for personal property brought to or left at the facility. I have been advised to leave personal property at home, unless specifically requested by a therapist to assist in my child's treatment.

Initials

Photography/Video Release

I **do / do not** (circle one) give consent for Steps Therapy, Inc. to take photographs and /or video for clinical, educational, and/or celebratory purposes.

Initials

Medicare Clients

Alta California Regional Center consumers are governed by the following policy as it relates to missed appointment:

- Second unplanned absence will result in termination of services. Exceptions will be made at Steps Therapy, Inc. discretion.

Initials

OVER DUE ACCOUNTS

Account balances must be paid within (30) days of the date billed. A due date will appear at the bottom of the invoice; if other arrangements have not been made then the credit card on file will be charged the balance due. If the credit card on file is refused you will be sent a follow-up reminder notice of payment due. After (90) days the account will be turned over to collections.

Initials

Cancellation & Late Policy

I understand that a fee of \$50.00 will be due upon the next scheduled visit if notice of a cancellation is received less than 24 hours before the scheduled appointment time, or if I fail to show up for any scheduled appointment. I further understand that three consecutive cancellations and/or “no shows” (a missed appointment without communication to our office), or habitual cancellations will result my child being discharged from therapy.

I understand that if I am consistently late to my appointment, a charge of \$30.00/15 minutes will be due upon each late arrival. I understand that if I leave the clinic I am expected to return at 15 minutes before the hour, and that if I arrive after the top of the hour a fee of \$1.00 per minute will be due. I also understand that the treatment session will end at the scheduled time, regardless of my late arrival.

Initials

Certification

I certify that any and all information given by me to Steps Therapy, Inc is correct, to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire. I have read this form (or it has been read to me) and I certify that I understand and agree to all of its conditions.

Signature

Date

Relationship to client

Insurance Verification

Today's Date:
Verified By:

Patient's Name:
DOB:

Subscriber Name:
Insurance Phone #:

Insurance Carrier:
Insurance Type:

Member ID:
Group ID:

Effective Date:
Deductible:
Amount Met:

Insurance Company mailing address:

Referral Required? Yes No

Authorization Required? Yes No

	Copay	Coinsurance	Visit Limit
Occupational			
Physical			
Speech			
Psychological			
	Per Day		All Therapies /year

*Note if co pay is per therapist session - or - per day regardless of the number of sessions in a day
 **Note if visit limit is for a specific therapy, a combination of therapies or for all therapies.

***LIMITATIONS/EXCLUSIONS/NOTES:**

Your insurance company has informed us that the benefits quoted to us are only an estimate and are not a guarantee of payment. By signing below, you agree that you have been informed of your benefits as quoted to us by your insurance company. You also agree that you have called your insurance to confirm these benefits. If you have not called your insurance company to confirm your benefits, Steps Therapy, Inc. is not liable for inaccurate information provided by your insurance company.

Patient / Authorized Representative

Date

Insurance Company Referral Acknowledgement

I (Patient) _____ am aware that Steps Therapy has recommended that I see my primary care physician for a prescription/referral even if my insurance company doesn't require that I have one.

I (Patient) _____ have spoken with my insurance company _____ . My insurance company has informed me that a prescription / referral are not required.

- All patient are expected to know and understand their coverage and benefits for therapy services. You can verify your benefits by calling the phone number on your insurance card and asking a representative from your insurance company. It is very important that you ask specifically about any “exclusions” or “limitations” to therapy benefits. Please use the attached Insurance Verification Form to guide you.
- Please remember that your insurance policy is between you and your insurance company. A quote of benefits from your insurance company is not a guarantee of payment.
- In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.
- It is illegal for our company to waive the co pay portion of your responsibility. Co payment is due at time of delivery of service(s). We accept check or credit card.

Patient / Authorized Representative

Date

Frequently Asked Questions

How long will the evaluation take?

We set aside two hours of a therapist's time for an evaluation, although the evaluation may not take that long. It will depend on your ability to participate, diagnosis, testing required, etc. Please have all your paperwork completed, and arrive on time for your appointment. You will need to bring your insurance card and prescription for therapy services, plus your credit or debit card.

How will the evaluation be structured?

The therapist will review your history information with you and discuss your concerns. Based on that information, any necessary testing will be administered. The therapists will then review the results of the test(s), discuss areas of delay or impairment, and make recommendations regarding therapy. If therapy is recommended, you may schedule the therapy sessions that day.

What if I have been evaluated at another facility but I want to come to Steps Therapy for therapy?

If your evaluation occurred within the last three months, we will accept the evaluation only if there is a plan of care (goals) attached. You may fax us a copy of the evaluation and plan of care and our therapists will review it to determine if it is a plan of care they can work from. If it is determined that the report and plan of care are acceptable, then we will contact you to discuss scheduling options. We will not promise or hold any appointments during this review time. Scheduling will only be discussed after our therapists have had an opportunity to review the documentation. If our therapist(s) determine that there is not enough information given in the report and plan of care, we will contact you to schedule a new evaluation.

What if I have to cancel my evaluation?

We require at least **48 hours notice** if you need to cancel or reschedule the evaluation. In the event that you do not show up for your appointment or provide at least 48 hours notice to cancel or reschedule the appointment, your credit card on file will be charged the full cost of the evaluation, which is \$385.00.

If services are recommended for me, how long will I need to receive therapy?

Recommendations for the frequency and duration of therapy services vary and will depend on your skill level and severity of delay or impairment. Other important factors that will impact your progress include consistent attendance, participation, daily practice, and carryover of therapy activities at home.

How long is a therapy session?

All therapy sessions are scheduled on the hour and are 25-50 minutes in length. The last 5-10 minutes of the hour will be used to discuss your therapy session and review any home activities the therapist recommends. Please keep in mind our therapists have very busy schedules and be respectful of their time by closing your discussions by the top of the hour. If you have additional questions or would like to discuss anything further, please email or call the therapist. If you feel you need a significant amount of time to talk to your therapist, you may schedule a consult appointment with your therapist. The charge for this appointment is \$40.00/30 minutes. This fee is due from you at the time of the appointment and will not be billed to insurance. This appointment is also subject to our cancellation policy.

Does insurance cover therapy services?

Steps Therapy will collect information to verify your benefits and eligibility. In addition we require that you contact your insurance company to inquire about your benefits for therapy services. At the time of your visit Steps Therapy, Inc. will collect an *estimated payment based on the information quoted to us by your insurance company*. Please understand that insurance benefits stated by your insurance company are not a guarantee of payment or coverage and are subject to medical necessity and eligibility at the time the claim is received. Should your insurance company deny payment, you are ultimately fully responsible for the total charges for services and/or treatment rendered.

What if I have more questions?

Our staff is available to answer any additional questions you may have. Please contact our office.

Privacy Statement

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.

Steps Therapy Inc, in compliance with the Health Insurance Portability and Accountability Act (HIPAA), maintains the privacy of protected health information (PHI), provides notice of our legal duties and privacy practices, and applies protections to how PHI is used and disclosed. CGH must abide by the terms of the notice currently in effect. The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we explain what we mean and try to give some examples. Not every use or disclosure in a category is listed. However, all the ways we are permitted to use and disclose information fall within one of the categories. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

FOR TREATMENT

- To provide, coordinate, and manage health care and related services by one or more health care providers
- To people outside Steps Therapy Inc who may be involved in your medical care after you leave

FOR PAYMENT

- To bill and collect payment for treatment and services provided to you
- To confirm coverage
- For utilization review activities

FOR EXAMPLE: A bill for your visit is sent to your insurance company for payment.

HEALTH CARE OPERATIONS

- For our business operations, such as conducting quality assessment and improvement activities, medical reviews, legal services, and auditing functions
- To review our treatment and services, and to evaluate our competency and performance
- For business planning, development, and management
- To decide what additional services we should offer, where we can make improvements in the existing care and services we offer, and whether certain new treatments are effective.

FOR EXAMPLE: An internal quality assessment review is conducted to determine the need for additional cardiac related services.

WE MAY CONTACT YOU

- To provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- For fundraising activities - only contact information is released, such as your name, address and phone number and the dates you received treatment or services.
- If you do not want to be contacted for fundraising efforts, you must notify the CGH Health Foundation.
- We may create and distribute de-identified health information by removing all references to individually identifiable information so others may use it to study health care and health care delivery without identifying specific patients.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

- To your personal representative, or family member or friend you indicate who is involved in your medical care.
- To inform your family or friends about your condition and that you are in the hospital.
- To an entity assisting in disaster relief effort so that your family can be notified about your condition, status and location.
- If you do not want this information shared, please inform an employee in the Registration office.

RESEARCH

- To researchers preparing to conduct a research project who need to know how many patients have a specific health problem.
- For research purposes if the research has been subjected to a careful review process conducted by a specially selected and trained committee and received this committee’s approval. This process evaluates a proposed research project and its use of health information, and balances the potential benefit of the research against individual’s need for privacy of their health information.

FOR EXAMPLE:

- A research project comparing the health and recovery of all patients who received one treatment to those who received another for the same condition. In that situation, you are not identified or contacted, but your health information may be used but kept confidential.
- A therapist caring for you believes that you may be interested in, or benefit from, a research study. Your therapist and the committee approve someone to contact you to see if you are interested in the study. At that time, you are contacted and provided with more information. You have the right to authorize continued contact or refuse further contact.

**THE FOLLOWING USES AND DISCLOSURES ARE REQUIRED BY LAW
AVERT A SERIOUS THREAT TO HEALTH OR SAFETY**

- To prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, is only to someone able to help prevent the threat.

PUBLIC HEALTH RISKS

- For public health activities. These activities generally include the following:
- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We only make this disclosure if you agree or when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES

- To a health oversight agency for activities authorized by law. These oversight activities include, for example, audit, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES

- In response to a court or administrative order if you are involved in a lawsuit or a dispute.

- In response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

LAW ENFORCEMENT

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at the hospital
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime

OTHER USES OF PROTECTED HEALTH INFORMATION

- Other uses and disclosures of health information not covered by this notice or the laws that apply to us are made only with your written authorization. You may revoke such authorization in writing at any time.
- We are required to honor and abide by that written request, except to the extent that we are unable to take back any disclosures we have already made with your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION RIGHT TO REQUEST RESTRICTIONS

- You have the right to request a restriction or limitation of the use or disclose of your health information for treatment, payment or health care operations.
- You have the right to request a limit on the disclosure of your health information to someone who is involved in your care or the payment for your care, like a family member or friend.

FOR EXAMPLE: You could ask that we not disclose to your friend information about a surgery that you had.

WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST

- If we agree with your request for restriction or limitation of the use or disclosure of your health information, we comply with your request unless the information is needed to provide you emergency treatment.
- To request restrictions, you must make your request in writing at the Steps Therapy Inc Registration, Health Information or Patient Accounts Department, Sterling, IL 61081. In your request, you must tell us
 - a. What information you want to limit
 - b. Whether you want to limit our use, disclosure, or both
 - c. To whom you want the limits to apply, for example, disclosures to your spouse

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

FOR EXAMPLE: You can ask that we only contact you at work or by mail.

- To request confidential communications, you must make your request in writing at the Steps Therapy Inc
- , 6960 Destiny Drive, Ste 117 Rocklin, CA 95677.
- We do not ask you the reason for your request. We accommodate all reasonable requests.

- Your request must specify how or where you wish to be contacted and how bill payment will be handled.

RIGHT TO INSPECT AND COPY

- You have the right to inspect and copy protected health information that may be used to make decisions about your care.
- Usually, this includes medical and billing records, but does not include psychotherapy notes.
- To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Health Information Department.
- If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Please allow at least 48 hours to accommodate your request.
- We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital reviews your request and the denial. The person conducting the review is not the person who denied your request. We comply with the outcome of the review.

RIGHT TO AMEND

- If you believe that health information we have about you is incorrect or incomplete, you have the right to request an amendment.
- To request an amendment, your request must be made in writing and submitted to the Steps Therapy Inc., 6960 Destiny Dr, Ste 117, Rocklin, CA 95677
- In addition, you must provide a reason that supports your request. This process does not include changes to PHI (protected health information) in demographic information (address, phone #, name change, etc).
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 - a. Was not created by us, unless the person or entity that created the information is no longer available to
 - b. respond to the amendment
 - c. Is not part of the medical information kept by or for the hospital
 - d. Is not part of the information which you would be permitted to inspect and copy
 - e. Is accurate and complete

RIGHT TO AN ACCOUNTING OF DISCLOSURES

- You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of health information about you that was released as described above due to required reporting.
- To request this list or accounting of disclosures, you must submit your request in writing to the Steps Therapy Inc.
- The first list you request within a 12-month period is free. We may charge for the cost of additional lists.
- We notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your existing, protected health information as well as any information we receive in the future. We post a copy of the current notice in all Steps Therapy Inc facilities. The notice contains the effective

date. In addition, each time you register at or are admitted to the hospital for treatment or health care services, we make a copy of the current notice available to you.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website *www.stepstherapyinc.com*

To obtain a paper copy of this notice, request from the front desk in main lobby area

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Steps Therapy Inc or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing with a description of the persons and acts or omissions that are the subject of the complaint. **YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.**

ACKNOWLEDGEMENT OF RECEIPT

Your written acknowledgement of having received this privacy practice notice is requested. Please sign and date the Notice of Privacy Practices Acknowledgement form on the first date of service or as soon as possible. Thank you