The staff at *Key Changes Therapy Services, Inc* would like to thank you for choosing us and welcome you to our family.

It is our goal at *Key Changes* to provide you with outstanding services, support, and communication regarding your family's needs. We provide an environment that is encouraging, well-informed, enjoyable, and sincere. We want you to be an integral and active participant in your child's therapy and learn how to provide an environment for your child and family that will support his/her development. We also want you to be involved in establishing goals, treatment planning, home exercises, and discharge planning. Our intention is to move towards a level of independence within everyone's abilities.

Included in our paperwork you will find:

- family/patient information sheet
- consent to treat/medical release/permission for exchange of info
- permission to leave site
- financial agreement/attendance policy
- HIPAA policy
- Audiovisual release

Please read all forms thoroughly so that you are informed about the agreements you are signing, and ask any questions to better help us serve you and your family.

Additionally, some other pieces of information are needed.

- Copy of driver's license
- Copy of the front and back of your insurance card
- Current prescription from PCP –Must state services 1x a week, for 12 months for specific diagnoses
- Most recent **OT/ST/PT** evaluations and progress notes within the past year

Thank you for allowing us the privilege of working with you and your family.

Thank you,

Natalie Mullis, MT-BC
Executive Director

Key Changes Therapy Services, Inc
1900 Sunset Blvd, West Columbia, SC 29169
Phone: 803-250-6833 Fax: 803-693-0850
www.keychangestherapy.com

PATIENT INFORMATION FORM

☐MUSIC THERAPY ☐SPEECH THERAPY ☐OCCUPATIONAL THERAPY

☐NEW INFORMATION!

Patient's Name (as appears on insurance card): _____ DOB: _____

Male / Female Parents' Names: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Cell Phone Number: _____

E-mail: _____ May we contact via text/email? Yes NO

Diagnosis (if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

Other doctors and specialists involved in your child's care:

Name	Specialty	Phone

How did you hear about Key Changes? _____

☐*NEW INFORMATION!*

Insurance Information:

Primary Insurance: _____Name of Insured:_____

Insured SS #:_____Insured's D.O.B:_____ Employer's Name: _____

Member ID:_____ Group #: _____

Claims Address (found on back of card):_____

Cust Service #:_____

I understand and agree to Key Changes Music Therapy Service, LLC, Notice of Privacy Practice.

Signature:_____Date:_____

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☐*NEW INFORMATION!*

Family Background:

Parent's Name: _____ Age: _____

Occupation: _____

Parent's Name: _____ Age: _____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Languages Spoken at Home (circle primary): _____

Is your child adopted? ☐ Yes ☐ No

Brothers(s) and Sister(s) of the child:

Name	Age

☐I have completed the online informational form.
If you have not completed the intake, it can be found at **http://tinyurl.com/KCMTSform**

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

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CONSENT TO TREAT

I, _____ consent for *Key Changes Therapy Services, Inc* to provide _____ ____ _____ with a speech and/or music therapy evaluation and subsequent therapy services. I consent to care and treatment falling under the practice guidelines of the American Music Therapy Association (AMTA), America Speech and Hearing Association (ASHA), National Board for Certification of Occupational Therapists (NBCOT) and the State of South Carolina. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

PERMISSION FOR EXCHANGE OF INFORMATION

I authorize *Key Changes Therapy Services, Inc* to release necessary and pertinent medical information to physicians, case managers, and insurance companies as needed, _____ .

Approved information may be exchanged with the following people *directly* related to patient's care:

☐ Other Therapists
☐ School Name: _____
☐ Please list any others: _____
_____

Approved information includes **written documents** and/or **verbal discussion.**

_____ _____

SIGNATURE **DATE**

_____

PRINTED NAME

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CHILD'S NAME:_____ **DATE OF BIRTH**: _____

FINANCIAL AND INSURANCE POLICY

A copy of your driver's license and insurance information is required before services begin. Benefits will be verified upon receipt of your insurance information and you will be made aware of any **estimated** out-of-pocket expenses before any services are started. Information obtained from insurance companies is **not always a guarantee of payment.** Families are ultimately responsible for payment for non-covered services. **It is imperative that families are aware of their insurance coverage and their potential responsibilities.** We will strive to keep open communication in regards to insurance and payment. Families will inform *Key Changes Therapy Services, Inc.* of any changes regarding insurance. Families assign benefits for filed claims to be paid to *Key Changes Therapy Services, Inc*. **Any payment sent directly to the family, intended to cover therapy services provided by *Key Changes Therapy Services, Inc.*, should be given to the desk.** _____parent initials

The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, the **full amount applied to your deductible will be billed to you.** *Key Changes Therapy Services, INC.* accepts Medicaid for speech and occupational therapy services and responsibilities are determined by plan. Please contact us directly if you do not have insurance coverage or are experiencing financial hardship. *Key Changes Therapy Services, Inc.* accepts cash, check, VISA, MASTERCARD, Discover, and American Express. There is a $50 fee for all returned checks. _____parent initials

We submit claims to insurance within one month of service dates. If payment has not been received within 60 days, the family will be responsible for the balance. If insurance makes payment, the family will be reimbursed any money that was paid for these services. If a family receives a bill that is not paid within 30 days of receipt of invoice, there will be a **10% late fee** added, and services risk being put on hold. _____parent initials

Key Changes Therapy Services, Inc. will file all **therapy** claims per our agreements with each insurance company. For private insurance, out of network benefits will apply. Please contact us to get an updated list of companies with whom we are in network. If authorization is required, therapists will submit based on need. Services will be administered after approval has been obtained.
_____parent initials

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ABSENCES AND CANCELLATIONS

Because of frequent no-shows and cancellations, *Key Changes Therapy Services, Inc,* has a policy that states that we require a **24 hour notice for cancellations.** After a one-time occurrence, a $35 fee *may* be charged for EACH missed therapy appointment.

Clients with less than 75% session attendance in a 12 week period **will be discharged from therapy**. Bi-Weekly appointments must maintain 85% attendance. We know that sickness occurs; therefore, if you think that your child is sick the night before, please call us and give us notice so we can plan accordingly. If your child is fine the next day, we will make every effort to reschedule them.

In the event of a cancellation, please make an effort on your part to reschedule as we want your child to benefit from his/her therapy. The staff at *Key Changes Therapy Services, Inc.* strives to meet the scheduling needs of every family. If your therapy time does not work for you, please let us know. **Making up missed therapy appointments is of the utmost importance in maintaining attendance percentages and keeping your appointment time. It is your responsibility to inquire with your therapist about openings for makeups.**

We consider the following signs to indicate communicable disease/illness and *request that you do not bring your child to therapy*: **Vomiting, Fever over 100 degrees, Diarrhea, Sore throat, Rash/Swelling, Red, or Running eyes.** Please be sure your child is symptom free for 24 hours before returning to therapy. If you have any questions about if your child is appropriate to bring to therapy, please call and ask.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

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Photo Use Authorization Form

By signing below, I am giving permission for Key Changes Therapy Services, Inc to use images and/or video of _____.

I hereby give permission for these images and/or video may be utilized for any of the locations I indicate below:

- ☐ Key Changes Therapy Services website and social media
- ☐ Online Advertisements
- ☐ Print Advertisements
- ☐ Presentation at Professional Conferences
- ☐ Scholarly Publications
- ☐ None

Should I select no usage, my sessions may still be recorded for usage as a part of the client's record and for the therapist to observe progress in sessions.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

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PERMISSION FOR PARENT TO LEAVE SITE DURING TREATMENT

I _____ (Parent or Legal Guardian) acknowledge that I am the parent of _____ (Name of Child). I understand that while my child is receiving therapy I may leave the premises. However, I will give *Key Changes Therapy Services, Inc.* a working cell phone number where I can be reached during my absence. In addition, I agree that I will not travel more than 10 miles from the satellite and I will return **prior to the end of the session.** I give consent and permission to *Key Changes Therapy Services, Inc.* for any additional treatment or transportation that may be needed in the event that my child is injured or needs medical attention. I understand that a failure to comply with the requirements listed above will result in immediate revocation of this ability. Also, I understand that the ability to continue to leave the premises while my child is at therapy is at the discretion of *Key Changes Therapy Services, Inc.* and/or my child's therapist.

I hereby release *Key Changes Therapy Services, Inc*, and any agents or assignees, from any and all claims for damages related to my leaving the premises during my child's therapy.

AUTHORIZED INDIVIDUALS FOR PICK UP

The below individuals are authorized to pick my child up from therapy:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____
PRINTED NAME **CELL #**

_____ _____
SECONDARY EMERGENCY CONTACT **PHONE #**

Key Changes Therapy Services, Inc
1900 Sunset Blvd, West Columbia, SC 29169
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Key Changes Therapy Services, Inc

Notice of privacy practices
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVUALLY IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your IIHI
Your privacy rights in your IIHI
Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Key Changes Therapy Services, LLC 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   i. Reporting child abuse or neglect
   ii. Preventing or controlling injury or disability
   iii. Notifying individuals if a product or device they may be using has been recalled
   iv. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. Our relationship with you does not confer any doctor/patient or similar privilege against disclosure.
4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
   i. Regarding a crime violation in certain situations, if we are unable to obtain the person's agreement
   ii. Concerning a death we believe has resulted from criminal conduct
   iii. Regarding criminal conduct at our office or at the individuals residence during the treatment
   iv. In response to a warrant, summons, court order, subpoena or similar legal process
   v. To identify/locate a suspect, material witness, fugitive or missing person
   vi. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. Deceased Patients. Our practice may release IIHI if requested by a government official.
6. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (ii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researchers agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.
7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
8. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities).
9. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals
11. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.
12. Parent or legal guardian or other disclosed person. We may disclose information to any other parent or legal guardian of the patient, or to the following person(s) who you are specifically designating to receive this information:

13. Any other person or organization who you may authorize us to provide information to, if that authorization is in writing and is dated and signed by you.
14. Your primary care and/or your referring physician.

The following categories describe the different ways in which we may use and disclose your IIHI

a.1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have additional tests such as MRI, and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write an evaluation or we may disclose your IIHI to an Occupational Therapist (OT), Speech Language Pathologist (SLP), or Physical Therapist (PT) if requested. Many of the people who work for our practice – including, but not limited to, our OTs, PTs, and SLPs – may use or disclose your IIHI in order to treat you or to assist others in your treatment, Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

a.2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

a.3. Health Business Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

a.4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

a.5. Health-Related benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

a.6. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter be with the child during treatment. In this example, the babysitter may have access to this child's information.

a.7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Key Changes Therapy Services, Inc 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Key Changes Therapy Services, 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169.Your request must describe in a clear and concise fashion:
   The information you wish restricted:
   Whether you are requesting to limit our practice's use, disclosure or both; and to whom you want the limits to apply.
3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Key Changes Therapy Services, Inc 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request in writing and submitted to Key Changes Therapy Services, Inc 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, an MT sharing information with another MT in the practice; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Key Changes Therapy Services, Inc 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before November 1st, 2006. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice or privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Key Changes Therapy Services, Inc 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169.
   Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Key Changes Therapy Services, Inc 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169
7. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact Key Changes Therapy Services, Inc 1900 Sunset Blvd, Suite 2, West Columbia, SC 29169.

Effective Date of this notice: January 1, 2019

Key Changes Therapy Services, Inc
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