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 Rousseau, 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? ____

Are you interested in volunteering for fundraising events? Y N Maybe

☐NEW INFORMATION!

<u>Insurance Information:</u>

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 #:____

KEY CHANGES
THERAPY SERVICES
UNLOCK THE MIND

Secondary 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:___________________

☐*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.

____ ____________________

PARENT/GUARDIAN SIGNATURE **DATE**

____

PRINTED NAME

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

KEY CHANGES
THERAPY SERVICES
UNLOCK THE MIND

CONSENT TO TREAT

I, ________________________ consent for *Key Changes Therapy Services, Inc* to provide _________ ____ _________ with a speech/music/occupational 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

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

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

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

KEY CHANGES
THERAPY SERVICES
UNLOCK THE MIND

I ______________________________________hereby consent to engage in teletherapy with Key Changes Therapy Services, Inc.. I understand that "teletherapy" includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

I understand the following with respect to teletherapy:
I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of KCTS, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. The KCTS currently uses Google Meet or Zoom to provide teletherapy services.

I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

Teletherapy has been determined as an appropriate service delivery model for this patient under current circumstances. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties, or keeping a child on task.
Teletherapy may be used as the primary means of service delivery, or may be used in combination with in-person services.

I have read, understand and agree to the information provided above.

________________________________	___________________________	__________
Signature	Relationship	Date

Key Changes Therapy Services, Inc | 83-0986896
1900 Sunset Blvd, West Columbia, SC 29169
Phone: 678-414-3042 Fax: 803-693-0850
www.keychangestherapy.com
Key Changes Foundation is a 501(c)3 organization and your contribution is tax deductible.

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
Phone: 803-250-6833 Fax: 803-693-0850
www.keychangestherapy.com

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 uses 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 "none", 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.

______________________________ ______________________

SIGNATURE **DATE**

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