



AMY ZIER & ASSOCIATES, INC.

Pediatric Therapy

www.amyzier.com

2319 N Orchard

Chicago, IL 60614

Phone: 773-755-7791 Fax: 773-755-7792

WELCOME!

We offer comprehensive evaluations at Amy Zier & Associates, Inc. Standardized as well as alternative testing methods are used in order to best learn about your child's individual profile.

Please complete the enclosed forms in order to assist with the evaluation/screening process.

If possible, try to return forms (via fax or mail) prior to the first evaluation date or bring them with you to the first scheduled session. We look forward to meeting with you.

**Remember to check that you've completely filled out all the forms completely including child's name at the top & your signature on the bottom—you do not need to sign this page.

Thank you

Signature _____

Date _____

CHILD'S NAME:



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Patient Data Form

Date: _____

Child's Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____ Work: _____

Email Address: _____ Cell: _____

Parent/Guardian Name(s): _____

Sibling(s) (Names/Ages): _____

Emergency Contact: _____

Phone: _____

Relationship to
Child: _____

How did you hear about Amy Zier and Associates, Inc? _____

What is your primary concern for having your child evaluated? _____

Has your child ever been evaluated before? yes no

If yes, please provide date/location and diagnosis if one was given: _____

Has your child ever received therapy services in the past? yes no

If yes, please provide location, therapists' names, type of therapy and important related information: _____

Is your child currently receiving any other therapy sessions or treatment programs? yes no

Signature _____ Date _____

CHILD'S NAME:



If yes, what type and intensity? Please list names and phone numbers to assist with team collaboration:

Who is your primary care physician? _____ Phone Number: _____

Address: _____

Is your child currently being treated by any doctors?

Name: _____ Address/Phone Number: _____

Name: _____ Address / Phone Number: _____

Has your child had an EEG? When and what were the results? _____

Is your child currently on any medication to treat Developmental Delay and/or abnormal EEG results? [] yes [] no

If yes, please indicate what type of medication and how long the child has been taking it: _____

Does your family have a history of mental illness (ex. depression, bipolar disorder)? _____

Does your family have a history of learning disabilities? _____

Is your child on a special diet?

Does your child have any food allergies?

Has your child seen a Nutritionist?

Is your child enrolled in a school program?

If yes, please provide name of school district, teacher's name/phone number and therapists' names/phone numbers:

Is there anything else we should know about your child? _____

Amy Zier & Associates, Inc will not submit invoices to insurance until paid in full. I understand that I am personally responsible for the total amount of any charges incurred through evaluation and treatment. Evaluations and screenings range from \$200-\$260 per hour. The hourly rate for sessions in the clinic setting ranges from \$168 to \$260 per hour for individual session. Group rates are \$125.00 per hour. Off site rates range from \$194 -\$210 per hour. Amy Zier & Associates, Inc. will provide documentation and assist to the best of our ability to obtain insurance coverage. Prices are subject to change.

Signature _____ Date _____

CHILD'S NAME:



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Consent for Release of Information

I, _____, authorize Amy Zier & Associates, Inc. to provide those
(Parent or Guardian of patient)
below with any information requested regarding the occupational therapy services for

_____.
(Patient name)

This information includes but is not limited to the demographic data, written records, financial records, and billing records of said patient. Please include the Name, Title and Relation to child for each person/institution listed. We can also get an updated prescription directly from your child's doctor if you list their information below.

1. _____
(Name) (Title) (Relationship to child)
2. _____
(Name) (Title) (Relationship to child)
3. _____
(Name) (Title) (Relationship to child)
4. _____
(Name) (Title) (Relationship to child)
5. _____
(Name) (Title) (Relationship to child)
6. _____
(Name) (Title) (Relationship to child)

Collaboration with other professionals is a priority to creating a comprehensive program supporting success. Please remember to include all necessary parties including pediatrician/family physician, insurance company, speech or physical therapist insurance advocate (Gail Borgerd), relatives, lawyers, schools, teachers, etc., any person/institution who may need information about your child's occupational therapy records.

If you have any questions, please contact our office at 773-755-7791.

Signature _____ Date _____

CHILD'S NAME:



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Payment Options

There are two payment options available once your child's evaluation is completed. Please check the option most convenient for you.

_____ CHECK

I will pay at the time the services are rendered by check. If you choose to pay for your child's session with a check, it MUST be given to your therapist on the day of service. For families with multiple children receiving services, an individual check must be written for each child's session. Please remember to put the date of service in the memo section of your check.

_____ CREDIT CARD

I understand that the AZ&A billing office will charge my credit card for services twice a month and will mail me an invoice. (Visa, Discover or MasterCard)

If you would like to pay twice a month with your credit card you must fill out a credit card authorization form prior to your child's first therapy session. Please note that AZ&A WILL NOT submit invoices to insurance until they are paid in full.

- Please email my invoices to:
- Please mail my invoices through the USPS

Signature _____ Date _____

CHILD'S NAME:



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Food Permission/Dietary Information

Please complete the following to inform Amy Zier & Associates, Inc. staff of your child's diet restrictions and in order to allow your child to participate in snack activities. **Attention: Our clinic is NUT & SOY FREE.** Please observe our restrictions when planning your child's snacks both in the waiting room & in sessions.

_____ My child may participate in snack time and has no diet restrictions.

_____ My child may participate in snack time if the following diet restrictions are observed.
Diet Restrictions:

_____ My child may participate in snack time; however, I will provide his/her snack.

_____ My child should not participate in snack time.

Please list the food(s) your child is motivated to eat:

Signature _____ Date _____

CHILD'S NAME:



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Photograph & Video Release

- _____ I give my permission for my child's picture/video to be used by Amy Zier & Associates, Inc. for the purpose of training other professionals or paraprofessionals and learning through supervision.
- _____ I give permission for my child's picture/video to be used by Amy Zier & Associates, Inc. for marketing/publicity.
- _____ I **do not** wish my child's picture/video to be used for any purpose other than training his/her specific clinical team and learning from supervisors.

Signature _____

Date _____

CHILD'S NAME:



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Amy Zier & Associates Policies

- 1. Payment at Time of Service:** Payment is due **in full** at the time of service. We accept credit card, cash or check payments. Your therapist will provide a letter of medical necessity, if necessary, at no charge. Children will be placed on hold if payment is not received within one week of the date of service.
- 2. Cancellation Policy:** We require a 24-hour notice in order to not be charged for the session. This is for all services (i.e. groups, individual, intensive, Parent/Guardian meetings and school meetings).
- 3. Sick Policy:** In order to maintain the health of the staff and children please do not bring your child if they have had a fever or experienced symptoms that may be contagious within a 24-hour period. If you find your child has lice or other contagious illness *after* attending the clinic, please notify us as soon as possible to allow us to implement precautionary measures as quickly as possible.
- 4. Consultation Policy:** Consultations are charged at the rate of an individual session. These include consultations with Parent/Guardian(s), other professionals and teachers regarding your child's treatment. Consultations may be in person or on the phone.
- 5. Documentation:** The following will be provided—evaluations, daily treatment summaries, initial letter of medical necessity, and bi-annual progress summary as needed at no charge. Additional documentation will be charged at the hourly rate.
- 6. Late pick-up:** In order to respect the appointments after your child's session please pick up your child on time. You will be charged 14.00 for every 5 minutes you are late for pick up.
- 7. Late drop-off:** In order to respect the therapist's time, please drop your child off on time. Charges will begin at the regular rate from the start time of the child's scheduled appointment, not from the time your child arrived & continue until the end of the session.
- 8. Allergen Alert:** Please note that our clinic is soy & nut free. Please do not bring snacks with you into the clinic that contains either of these ingredients. Some of the children are extremely allergic & we ask that you respect this policy. If you have any special dietary needs, please notify us in the food section of this packet.

Signature _____

Date _____

CHILD'S NAME:



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Request for Therapy Prescription

January, 2005

Illinois State Law mandates that we have a written prescription from your child's doctor prior to starting treatment. These must be **updated every six months** and we must have a current prescription in your child's file at all times. Please have the prescription faxed to the clinic or give it to your therapist prior to treatment. If you have additional questions, please speak to your therapist.

We can have your prescription updated automatically; simply list your child's pediatrician's information in the consent to release section and we will call your pediatrician once the prescription expires.

Are you interested in having Amy Zier & Associates contact your pediatrician on your behalf to update the prescription? Check to make sure you have listed your primary care physician's information under the **Consent to Release Information** form.

Signature _____

Date _____

CHILD'S NAME:



Getting Coverage for Occupational Therapy

Insurance companies can be complicated and all plans are different. This information is intended to give you an idea of how to find out what benefits are available to you in your health care plan. Before you begin Occupational Therapy, it's important to ask your insurance carrier about your OT benefits. You can do this yourself using the customer service number on the back of your card or we can do it for you. Simply contact the billing office at 773-755-7791 with your insurance information on hand. If you plan to call yourself, these are some questions you may want to ask:

1. Does my plan cover Occupational Therapy from an “out of network” provider?

Amy Zier & Associates, Inc. does not participate in any health insurance plans. Therefore any services rendered through us are considered “out of network” for your insurance.

2. Is there a cap on OT benefits either monetary or number of sessions?

Some insurance companies have a maximum dollar amount or a maximum number of sessions that they will cover. A monetary cap on OT benefits refers to the maximum dollar amount that your insurance covers. The number of sessions cap refers to the maximum number of sessions that your insurance will cover in the fiscal year. It's important to know the cap for your plan. If you should happen to reach this cap, we can contact your insurance company to find out how to apply for more.

3. Do I have a deductible?

A deductible refers to the amount you have to pay out-of-pocket for services before the insurance company will cover the remaining costs. If you have a deductible, this means that you will have to pay the amount for services IN FULL until you reach the amount and your benefits kick in. It is important to keep track of your deductible. Your insurance will also track this, but it's always smart to be informed.

4. What is my out of pocket max and what happens when I reach that dollar amount?

Most health plans have an out of pocket maximum per year and per person on the policy. This refers to the total dollar amount that you, as the insured, are responsible for per year regarding covered services. If you reach the max out of pocket amount, your insurance may either begin covering services 100% or have some other alternative.

This is only a helpful starting point in working with insurance companies. If you ever have any questions or any difficulties, our billing office can help handle questions and concerns. We also regularly consult with Gail Borgerd, an insurance expert to support families getting the most coverage possible.

Signature _____

Date _____

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Insurance Options

Amy Zier and Associates sends invoice documentation to families twice a month. In addition AZ&A will submit invoices directly to your insurance company if you prefer. Please indicate your preferred method of insurance submission below.

_____ **DO NOT** Submit my invoices to insurance. I will submit documentation as needed.

_____ Submit my invoices to my insurance listed below.

Carrier _____

Group number _____

ID number _____

Claims address _____

Customer service phone number:

Date insurance policy is effective or date we can begin submitting:

Provide a copy of BOTH sides of your insurance policy card

If you would like us to submit to insurance, payment is still due at time of service. Please remember that AZ&A will **not** submit invoices to insurance until they are paid in full. We must have a copy of BOTH sides of the insurance card as well as a current prescription.

Signature _____ Date _____

CHILD'S NAME:



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NOTICE OF PRIVACY PRACTICES

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. **KEEP THIS COPY FOR YOUR RECORDS***

This notice takes effect on

and remains in effect until we replace it.

1. OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your child's medical information is important to us. We understand that your child's medical information is personal and we are committed to protecting it. We create a record of the care and services your child receives at our organization. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about your child. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your child's medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your child's medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided, that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR CHILD'S MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your child's medical information for any purpose not listed below, without your specific written authorization. Any specific

Signature _____

Date _____

CHILD'S NAME:



written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about your child to provide your child with medical treatment or services. We may disclose medical information about your child to therapists, doctors, nurses, technicians, student therapists, or other people who are taking care of your child. We may also share medical information about your child to your other health care providers to assist them in treating your child.

FOR PAYMENT: We may use and disclose your child's medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your child's medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your child's medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve your child.

ADDITIONAL USED AND DISCLOSURES: In addition to using and disclosing your child's medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or other person responsible for your child's care. We will share information about your location and/or your child's general condition. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of .emergency, «and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your child's health care, according to our professional judgment. We will also use our professional judgment to make decisions in your/your child's best interest about allowing someone to pick up supplies or medical information.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with the coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel, for national security & intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, Discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your child's medical information .with law enforcement officials. We

Signature _____

Date _____

CHILD'S NAME:



may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of a person in lawful custody with law enforcement official(s) or institution(s) under certain circumstances.

Public Health Activities: As required by law, we may disclose your child's medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your child's medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your child's medical information if it is necessary to prevent a serious threat to your child's health or safety or the health and safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations/proceedings, inspections, Licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have the Right to:

1. Look at or get copies of certain parts of your child's medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request

Signature _____ Date _____

CHILD'S NAME:



- access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice.
2. Receive a list of all the times we or our business associates shared your child's medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
 3. Request that we place additional restrictions on our use or disclosure of your child's medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergencies).
 4. Request that we communicate with you about your child's medical information by different means or to different locations. Your request that we communicate your child's medical information to you by different means or at a different location must be made in writing to the contact person listed at the end of this notice.
 5. Request that we change certain parts of your child's medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
 6. If you have received this not electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice, or you may print out a copy.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U. S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Amy Zier & Associates
ATTN: CLINIC ADMINISTRATOR
2319 N. Orchard Street
Chicago, IL 60614

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

KEEP THIS COPY FOR YOUR FILES

Signature _____

Date _____

CHILD'S NAME:



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Receipt of Privacy Policy Notice

I, _____ have received a copy of the "Notice of
(Parent/Caregiver)

Privacy Practices" from Amy Zier & Associates, Inc. with regard to the treatment of

(Child's Name)

**A photocopy of this form is authorized to serve same as original.

Signature _____ Date _____

CHILD'S NAME:



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Once you have read through and understand all the material provided in our parent packet, please initial and sign. Please return all completed forms along with this form to the therapist that is providing your child's evaluation.

I have read, understand & agree to the following:

- _____ Insurance Options
- _____ Sensory Profile/Caregiver Questionnaire
- _____ Patient Data Form (2 pages)
- _____ Consent for Release of Information
- _____ Photograph & Video Release
- _____ Food Permission/Dietary Information
- _____ Request for Therapy Prescription
- _____ Amy Zier & Associates Policies
- _____ Payment Options
- _____ Credit Card Authorization
- _____ Privacy Policy Notice

Signature _____ Date _____