



Phone:(803) 602-4744

Fax: (803) 602-6466

Email: info@itsallfuntherapy.com

Therapy Consent Packet

To Assess Client and Obtain/Release Information It's All Fun Therapy Services, LLP requests this information for the purpose of completing a thorough evaluation with your child. Depending on your child's abilities, some questions may not be applicable.

Client Name

Date of Birth

Age

Gender

Parent(s)/Guardian Name

Person Providing Information

Address

Daytime Phone

Evening Phone

Email address

Part One: Consent for Therapy Assessment

I, the undersigned client or parent/guardian authorize the Physical/Occupational Therapist

- Perform Assessments
 - Provide recommendations, resources and training
- (As deemed necessary per client.)

I understand the results of the assessment and the recommendations will be discussed with me.

Signed: _____ Date _____
Relationship to client _____

Part Two: Consent to Obtain and Release Information

_____, I, the undersigned client or parent/guardian, authorize the Physical/Occupational Therapist to:

Obtain information and/or records from relevant agencies and individuals, e.g., medical facilities, physicians, schools, health units, etc.

- Release information and/or records to relevant agencies and individuals, as discussed and deemed necessary by the client.
- Discuss pertinent information with representatives of relevant agencies and individuals. (As such information relates to the client's therapy services)

Signature _____ Date _____
Relationship to client _____



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Insurance Information Form

Client Name

Client SSN

Primary Source of Insurance

Insurance Phone Number

Policy Holder Member

ID/Policy #

Group #

Secondary Source of Insurance

Insurance Phone Number

Policy Holder Member

ID/Policy #

Group #

Account Payment

- I request and authorize my insurance company and/or Medical Assistance Program to make payments of authorized benefits on my behalf to It's All Fun Therapy Services, LLP.
- I agree that office co-pays/insurance and any amount not paid by my insurance becomes my obligation and give It's All Fun Therapy Services, LLP permission to bill me directly upon denial.

Signature of Parent/Legal Guardian or Responsible party Date



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**Release of
Information/Confidentiality/Policy/Emergency Contact**

I give permission to It's All Fun Therapy to release and/or obtain information regarding services, as well as educational and/or medical information pertaining to my son/daughter.

Child's Name

Name: _____ Telephone: _____

Address: _____

Special Education Teacher

Occupational Therapist

Physical Therapist

Service Coordinator

School District

Physician

Other

Other

Daycare Providers

Preschool Teachers

It's All Fun Therapy has provided me with a copy of their confidentiality policy, and Notice of Privacy practices (HIPAA), Parental Access to Records (FERPA), as well as internal quality assurances and has reviewed their scheduling, cancellation and health/safety policies with me.

Date: ___/___/___ Parent/Guardian Signature _____ Please

indicate who should be contacted in the event of an emergency:

Name/Relationship Phone Number



Photo/Video/SeeSaw Release Form

I hereby authorize It's All Fun Therapy Services and those acting pursuant to its authority a nonexclusive grant to:

a. Record my child's likeness and voice on video, audio, photographic, digital, electronic, online formator on any and all other media.

b. Use my child's name in connection with these recordings.

c. Use, reproduce, publish, republish, exhibit, edit, modify, or distribute, in whole or in part, these recordings in all media without compensation for any purpose that Its All Fun Therapy Services, LLP and those acting pursuant to its authority, deem appropriate, including promotional or advertising efforts. These recordings may appear in a variety of formats and media now available to Its All Fun Therapy Services,LLP and that may be available in the future (e.g. print publications, video tapes, CD-ROM, internet, mobile, digital).

I hereby release It's All Fun Therapy Services, LLP and those acting pursuant to its authority from liability, claims, and demands for any violation of any personal or proprietary right I or my child may have in connection with such use, including any and all claims for libel, defamation, or invasion of privacy. I understand that all such recordings, in whatever medium, shall remain the property of Carolina Therapy Solutions for Kids.

I have read and fully understand the terms of this release.

- I give my permission for Its All Fun Therapy Services,LLP to take and use my child's photo/name as stated above.
- I would prefer my child's photo/name NOT be used as stated above.

Child's Name

Date

Parent/Legal Guardian Signature

Parent/Legal Guardian Printed Name

Relationship to Child



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Communications Release Form

I hereby authorize It's All Fun Therapy Services permission to contact and communicate in the following ways:

Please check all that apply:

I have read and fully understand the terms of this release.

- Phone Text
- Email Voicemail
- ClinicSource

Child's Name

Date

Parent/Legal Guardian Signature

Parent/Legal Guardian Printed Name

Relationship to Child



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History/Concerns

When did you first have concerns about your child? What were your concerns?

Which techniques or strategies have you been attempting independently?

Was there a NICU stay? If so, how long?

What age did your child sit, crawl, stand?

What is your primary concern today?

Which specific skills would you like your child to achieve through therapy?

Any Current Diagnoses?

Any aversions to different textures?

Pr

Pregnancy and Birth History:

1. Were there any illnesses, injuries, bleeding, or other complications during your pregnancy?

2.

Was your pregnancy full term? If not, please give gestational age.

3. Was labor and delivery atypical?



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Pregnancy and Birth History (continued):

4. What was your delivery method (vaginal, breech, cesarean)? _____

Were forceps or suction used? _____

5. Was oxygen or respiratory assistance required after birth? Please circle: YES / NO (if yes, please explain)

6. Did you experience any complications with feeding? Please circle: YES / NO (if yes, please explain)

7. How was your child fed as an infant? Please circle: Bottle / Breast / Other: _____ Until what age? _____

8. Please list any concerns regarding your child's eating habits:

Medical History:

Has your child experienced any of the following? (Please check all that apply)

- Chicken Pox
- Vision Problems
- Seizures
- Sensory Processing Challenges
- Feeding difficulties
- Frequent ear infections or fluid in the ears
- Socialization challenges
- Difficulty adjusting to routine changes
- Difficulty meeting milestones

2. Is your child currently taking any medications? (If yes, please list)



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Medical History (continued):

3. Does your child have any known food allergies? (if yes, please list)

4. Has your child's hearing been evaluated recently? (if yes, when, by whom and what were the results?)

5. Are there any precautions we should know about that are not described above?

Play and Social Skills:

1. Does your child engage in eye contact during communication? Yes / No / Sometimes

2. Do you use communication devices with your child (PECS, AAC, sign, etc.)? Yes / No If yes, please describe: _____

3. When given a choice, does your child prefer to play alone or with others? Alone/Others

4. How does your child interact with others (shy, aggressive, cooperative, etc.)?

5. Does your child:

- Answer questions logically? Yes / No / Sometimes
- Maintain attention during play? Yes / No / Sometimes
- Greet people arriving or leaving? Yes / No / Sometimes
- Initiate play with peers? Yes / No / Sometimes
- Engage in turn taking? Yes / No / Sometimes
- Initiate conversation? Yes / No / Sometimes
- Follow one-step directions? Yes / No / Sometimes

Play and Social Skills (continued):

6. What are some of your child's favorite toys/interests?



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Education:

1. Does your child attend school? If yes, where and how often?

2. What grade is your child presently in? _____

3. Please list any services your child receives at school (speech, occupational therapy, physical therapy, tutoring, etc.)

4. May we communicate with the school therapists to collaborate services? Yes / No(If yes, please list their information on the "Consent for Release" form and provide a copy of your child's most current IEP)

5. Does your child experience any specific challenges in school? If yes, please describe:



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CLIENT/CHILD CONFIDENTIALITY POLICY/PROCEDURE STATEMENT

1. As a healthcare provider: It's All Fun Therapy Services, LLP, practicing as a licensed therapist in the state of South Carolina, this therapist shall function with discretion and integrity in relation to Patients/clients. Said therapist will protect the privacy of each client with reference to Federal and State Requirements. In addition, the client/patient/child's individually identifiable health information (IIHI) is guaranteed to be kept confidential. Therapist will also follow confidentiality requirements contained in South Carolina Code of Laws 44-115-10 et seq., IDEA, Title 34 Code of Federal Regulations and Federal Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA). As a South Carolina licensed professional practicing within the Early Intervention program, the records will be retained in accordance with laws and regulations that apply to my profession. 2. South Carolina Department of Health defines "confidential HIV related information" as. Any information in the possession of a person who provides health or social services or who obtains the information pursuant to the release of confidential information concerning whether an individual has been the subject of an HIV related illness or AIDS, or information which identifies one, or could reasonably identify an individual, as having one or more of such condition, including information pertaining to such individual contacts. Therefore, confidential information according to South Carolina Code of Laws 44-115-10, et seq., IDEA, Title 34 Code of Federal Regulations and Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) will be followed.

3. No written or verbal exchange of information about the patient/client/child can occur n without prior written parental consent unless otherwise stipulated by the South Carolina Code of Laws 44-115-10, et seq., IDEA, Title 34 Code of Federal Regulations and Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) or laws that regulate my profession. Parents/legal guardians have the rights to access their child's records at any time. The Early Intervention official and approved evaluators, service providers and service coordinators shall ensure the parent is afforded the opportunity to review and inspect all of the records pertaining to the child and the child's family that are collected, maintained or used for the purpose of the Early Intervention

Program, unless the parent is otherwise prohibited such access under state or federal law. The opportunity to review and inspect the record includes the right to (i) understandable explanations about and/or interpretation of the record upon the parent's request; (ii) obtain a copy of the record within 10 working days of the receipt of the request by the Early Intervention official or approved evaluator, service provider or service coordinator;

(iii) obtain a copy of the record within five working days if the request is made as part of a medication or impartial hearing, (iv) have a representative of the parent review the record. This provider will keep a record of parties obtaining access to records



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gathered, maintained, or used for purposes of the Early Intervention Program (except access by parents and authorized employees of the municipality or approved evaluator, service provider, or services coordinator) including the name of the party, the date access was given, and the purpose for which the party is authorized to use the records. A signed release from the child's parent or legal guardian is necessary, specifying therapeutic team members, physicians, and/or agencies accessing the client's records are directly documented in the chart access record kept in the client's file.

4. All client/patient/child records are maintained in a locked cabinet for this therapist's exclusive use. All client records are stored separately from inactive records. When a client/patient/child's chart or information relating to client/patient/child is transported it is stored in a locked sturdy container in a locked car or will be directly on the therapist's person. Client/patient/child records will be maintained in a locked file cabinet for a period of seven years from the last billing or until a client/patient/child reaches 21 years of age.
5. The therapist's home computer is password and firewall protected ensuring that no one can have access to these records or identifying information pertaining to a client/patient/ child at any time. Any electronic information related to a child/client will be kept on a separate disk in a locked disk box and file box. If the therapist is working on any information relating to a child it is to be done in a separate room with computer screens and identifiable papers kept covered if not immediately working on it. If service provider needs to leave space for ANY length of time, ANY identifiable information will be locked in files or closed down on computer and disk locked up to insure confidentiality. ANY phone calls regarding child/client will be done in a separate room free of other people. ANY electronic communications regarding child/client will be completed with generic information without any identifiable information disclosed. ANY faxed information is provided a confidentiality statement with discretion ensured that the recipient of said faxed information is aware that the information is forthcoming. ANY information that is discarded will be shredded to assure confidentiality for patient/client/child.
6. Upon initial visit of a new patient/client/child the parent or legal guardian of each patient/client/child given a copy of an in depth Notice of Privacy Practices as well as this Confidentiality Policy/Procedure Statement. A Checklist Form (Policies and Procedures) will be

provided to the parent/legal guardian to indicate the receipt of this provider's

- ✓ Notice of Privacy Practices/Confidentiality Policy
- ✓ Confidentiality Policy/Procedure Statement
- ✓ Cancellation Policy
- ✓ Health and Safety Policy
- ✓ Parental Access to Records Form



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- ✓ Permission to Evaluate Form
- ✓ Release of Information Form

7. The parent/legal guardian will be asked to sign the Checklist Form, Release of Information Form, and Permission to Evaluate Form and Parental Access to Records Form. These signed forms will be kept in each child's chart.

I, _____, the parent/legal guardian of _____ have read the Notice of Privacy Practices/Confidentiality Policy and the above Confidentiality Policy/Procedure Statement and am aware that I may have access to my child's file at any time. I am also aware that my written consent is needed for any release or attainment of information at any time.

Parent/Legal Guardian Signature Date

date



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NOTICE OF PRIVACY PRACTICES/CONFIDENTIALITY POLICY

This notice describes how records for _____ (client), including medical information, will be used and disclosed, and how the parent/legal guardian (“you/your”) can get access to this information. This notice incorporates policies from the Health Insurance Portability and Accountability Act (HIPAA) and Federal Family Educational Rights and Privacy Act (FERPA) and regulations (34 CFR part 99), Individuals with Disabilities Act (IDEA) and regulations (34 CFR 303; 34 CFR 300.560 through 300.576), South Carolina Code of Laws 44-115-10 et seq., Medical Assistance Program (Medicaid) and general professional practice policies. Please read the following.

COMMITMENT TO CLIENT’S PRIVACY

It’s All Fun Therapy Services, LLP (“provider”) is dedicated to maintaining the privacy of the clients’ records. This provider will follow confidentiality procedures, which adhere to the Title 34 of the Code of Federal Regulations. In conducting business, the provider will create records regarding the client and the treatment services provided to the client. The provider is required by law to maintain the confidentiality of information that identifies the client. The provider is also required by law to provide you with a notice of legal duties and the privacy practices maintained in the practice concerning the client’s records/identifying information (“II”). This provider will provide a copy of the practice policies on the initial visit. By federal and state law, the provider must follow the terms of the notice of privacy practices in effect at this time. As a licensed Therapist, I am obligated under South Carolina Education law to retain your child’s records in accordance with the laws and regulations that apply to my profession.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH THE CLIENT’S RECORDS, INCLUDING HEALTH INFORMATION MAY BE USED, DISCLOSED, AND STORED.

Written parental consent must be obtained before personally identifiable information is disclosed to anyone other than the authorized individuals. If the purpose is for any other reason, the parent will be informed of the names of the individual’s request access and the reason for the access, and provide written consent for the access. If consent is given, those individuals must also be informed about, and required to adhere to, the confidentiality policies and procedures of this provider and must adhere to all

legal requirements that protect EIP records containing service information.

1. Receiving Referral. Upon receipt of referral, it is understood that the referral source (e.g., Early Intervention Program, School District) has previously obtained written permission from the family to disclose information to the treatment team involved in providing services.



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2. To provide treatment. The provider may use or disclose identifying information to coordinate care with approved team members, family members, or caregiver **only as designated by the Consent to Release and Obtain Information form, signed by you.** Collaboration with other team members will be accomplished through a variety of communication methods (while maintaining confidentiality procedures) with a frequency that meets the individual needs of the family.
3. To obtain payment. The provider may use and disclose the clients II to the Early Intervention Program or Preschool Program to obtain payment for services rendered.
4. Reviews and Audits. The provider may use and disclose II for review and auditing, including compliance reviews, medical reviews, legal reviews, legal services, and compliance programs. A record will be kept of any individual, other than you, who access your child's record along with the date and purpose for which the record was accessed.
5. For appointment reminders. The provider may use or disclose the client's II to contact family as a reminder that the client has a scheduled visit.
6. When legally required. The provider will use and disclose the client's II when he/she is required to do so by federal, state or local law.
7. Re-release of information. Information received members of the team (e.g., Core Evaluations, Supplemental Evaluations, Physical Exams, IFSPs, IEPs, etc.) cannot be re-released, unless specific consent to do so is given by you. The only information that will be released upon signed consent or subpoena is that which has been directly generated by the provider (e.g., the clinicians daily and monthly progress notes, quarterly summaries, evaluative reports, etc.) Written parental consent for re-release of or obtaining information must include the name of the entity, which records will be obtained or released; the specific record to be used and the purpose of such use; the date the parent signed the consent, and the parent's signature and relationship to the child. When a general release is used the parent shall be informed of the right to refuse to sign a general release and offered the opportunity to sign a more selective release.
8. Maintenance and Retention of records. Written reports will be kept in a secure, locked area/receptacle. Under no circumstances is documentation to be given to another party (e.g., Spouse) for faxing, etc. If records are required to be

transported by vehicle, they will be secured in a locked box or container and kept out of direct sight. All reports that are created by a computer will be saved to disc and kept in a locked receptacle.



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- At a minimum, records must be retained for 6 years from the date of that care/services were provided to the client/child and family.
- I will retain records in accordance with the laws and regulations that apply to my profession.
 - I will adhere to all Medicaid requirements, including preparing and maintaining contemporaneous records.
 - Any electronic documentation will be maintained in a manner that demonstrates the provider's right to receive payment under the Medicaid program. The confidentiality of all information maintained in the electronic format will be ensured.

9. Reporting Progress. Written and oral reports will be made to the Early Intervention Program, School District, and/or the Preschool County Municipal Representative of each visit and progress toward parents and/or educational goals.

THE FOLLOWING IS A SUMMARY OF THE SPECIAL CIRCUMSTANCES IN WHICH THE PROVIDER MAY USE OR DISCLOSE CLIENTS IDENTIFIABLE INFORMATION (II), INCLUDING HEALTH INFORMATION.

The provider may use the client's II and share it with others, in order to treat the client in an emergency or to meet important school needs. The provider is not required to obtain client's written authorization, consent, or any other type of permission before using or disclosing client's information for these reasons: 1. Public Health Risks. The provider may disclose the client's II to public health authorities that are authorized by law to collect information, including reporting child abuse or neglect.

2. Health Oversight Activities. The provider may disclose the client's II to a health oversight agency for activities authorized by law. Oversight activities can include 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 the civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. The provider may use and disclose the client's II in response to a court or administrative order if subpoenaed to do so.



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4. Law Enforcement. The provider may release II if asked to do so by a law enforcement official:

- Regarding criminal conduct within a therapy session and/or to report a crime.
- In response to a warrant, summons, court order, subpoena, or similar legal process.
- To identify/locate a suspect, material witness, fugitive, or missing person. • In an emergency.

5. Serious threat to Health or Safety. The provider may use or disclose the client's II when necessary to reduce or prevent serious threat to the client's health or safety or to the health and safety of another individual or the public. Under these circumstances, the provider will only make disclosures to a person or organization able to help prevent the threat, in accordance with South Carolina and Federal Law.

YOUR RIGHTS REGARDING THE CLIENT'S IDENTIFIABLE INFORMATION (II). You have the following rights regarding the II that the provider maintains about the client. 1. Confidential Communications. Early Intervention Program regulation South Carolina Code of Laws 44-115-10 et seq., states that personally identifiable information, or records pertaining to an eligible child shall not be disclosed by an office or employee of the Department of Health, state early intervention service agencies, municipalities, evaluators, service providers or service coordinators, to any other person than the parent of such child, except in accordance with Title 34 of the Federal Rules part 99, sections 300.560 through 300.576 to preserve the confidentiality of records pertaining to children participating in the early intervention program (EIP). Individual authorized to routinely access EIP records must be informed about, and required to adhere to, the confidentiality policies and procedures of the EIP and must adhere to all legal requirements that protect EIP records containing sensitive information. Early intervention officials, all providers approved to deliver early intervention services and all personnel involved in mediation an impartial hearing procedures shall implement and maintain policies and procedures to assure the protection of confidential personally identifiable information, which may include existing policies and procedures where appropriate and applicable, submit assurances that all employees, including independent contractors, consultants, and volunteers with access to requirements of personally identifiable information, adhere to all legal requirements that protect record that which contains sensitive information (e.g., such as sexual or physical



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abuse, treatment for mental illness, or mental health problems, HIV status, communicable disease status, the child's parentage, etc.) and identify the person or persons with designated responsibility for guaranteeing the confidentiality of personally identifiable information. When early intervention records containing information about multiple children, when you request access to your child's record, you will only receive the record(s) pertaining to your family. The personally identifiable information about others must be protected. You have the right to request that the provider communicate with you in a particular manner or at a certain location. The provider, while conducting normal business practices, may contact you via telephone, cell phone, answering machine, fax, e-mail, or in writing. In order to request an alternate type of confidential communication, you must make a written request. The provider will accommodate reasonable requests. You do not need to give a reason for the request. The provider will keep all information imparted in a manner consistent with ensuring confidentiality and privacy. Telephone calls will be received and made in private with no one else present. Verbal discussions with other team members will be conducted in the same manner. E-mails will contain no II to ensure confidentiality is maintained.

2. Requesting Restrictions. You have a right to request a restriction in the provider's use or disclosure of the client's II for treatment, payment or health care operations. Additionally, you have the right to restrict the disclosure of the client's II to only certain individuals involved in the client's care or the payment for the client's care, such as family members and friends. The provider is not required with the client's request; however, if the provider does agree, she is bound by the agreement except when otherwise required by law, in emergencies or when information is necessary to treat the client. If you wish to make a request for restrictions regarding the disclosure of the client's II, please submit a written request.
3. Inspection and Copies. You have the right to inspect and obtain a copy of the II that may be used to make decisions about the client, including the client's treatment and billing records. As permitted by Federal regulations, this provider requires that request to inspect or copy protected treatment records be submitted in writing. The provider may provide a fee for the costs of copying, mailing, labor and supplies associated with your requests as permitted by law. A fee not to exceed 10 cents per page for the first copy and 25 cents per page per additional copies may be charged to the client/parent to copy EI records, unless the fee prevents the parent from inspecting and reviewing the record. No fee may be charged for records related to evaluations and assessments or for the search and retrieval of records.



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4. Access to, and amending, Records. You have the right to review all your records pertaining to you or your child. You may have a representative on your behalf unless such access is prohibited under State or Federal Law. Only individuals who collect or use information for the express purposes of facilitating the child/family's participation in the EI program should be authorized to routinely access a child's record. These individuals must be identified within a provider agency. You may ask the provider to amend the client's record if you believe it to be inaccurate, misleading, incomplete or violates the privacy of any other rights of their child. To request an amendment, it must be completed in writing. You must provide the provider with a reason that supports your request for an amendment. A response to the amendment request by the provider (if directed towards the provider) must be made within 10 working days. The provider will deny the request if it is not submitted in writing. Also, the provider may deny your request if you ask him/her to amend anything that is in their opinion: (a) inaccurate and incomplete; (b) not part of the records kept by or for their practice; (c) not part of the record which you would be permitted to inspect or copy; or (d) not created by her practice; unless the individual entity that created the information is not available to amend the information. You have a right to obtain a hearing if the suggested amendment was refused. You have the right to include a statement to be kept and disclosed with the record if the record is not amended as a result of the hearing. Written parental consent must be obtained before personally II is disclosed to anyone other than authorized individuals. If the purpose is for any other reason, (e.g., record review for quality assurance by individuals not directly involved in the child/family's participation in the EI program), the parent must be informed of the names of the individuals that request access and the purpose for the access, and provided written consent for such access. All parties obtaining access to Early Intervention records (except access by Parent/Legal Guardian or authorized persons by law), will record their name, the date access was given, and the purpose for which the party is authorized to use the records. If consent is given, those individuals must be informed about, and required to adhere to, the confidentiality policies and procedures of the EIP and must adhere to all legal requirements that protect EI records and sensitive information (such as sexual or physical abuse, HIV status, treatment for mental illness, the child's parentage, etc.)
5. Accounting Disclosures. You have a right to receive a list of instances in which the provider disclosed the client's II for the purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before 27 September 2017. If you request this accounting more than once in a 12-month grace period, the provider may charge you a reasonable, cost based fee for responding to these additional requests.
6. Right to a paper copy of this notice. You have a right to a separate paper copy of this notice at any time, even if you have received this notice previously. Please contact this provider for an additional copy.



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DUTIES OF THIS PROVIDER

The provider is required by law to maintain the privacy of the client's II and provide you this notice of its duties and privacy practices. The provider is required to abide by the terms of this notice. The provider has the right to change the terms of this notice and make new notice provisions effective for all records, including health information that is maintained. The provider will provide you with a copy of any changes in this notice. You have a right to file a complaint if you believe the client's privacy rights have been violated. You will not be retaliated against in any way for filing a complaint. Therapist will review Early Intervention Regulations regarding confidentiality requirements (personally identifiable data, information or records to an eligible child) on a quarterly basis to ensure that therapist remains current with confidentiality requirements.

RIGHT TO PROVIDE AUTHORIZATION FOR OTHER USES AND DISCLOSURE The provider will obtain your written authorization for uses and disclosure that are not incentivized by this notice or permitted by applicable law. Any authorization you provide to the provider regarding the use of the client's II may be revoked at any time in writing. After you revoke your authorization, the provider will no longer use or disclose the client's II for the reasons described in the authorization. Please note: the provider is required to obtain records of the client's care.

EFFECTIVE DATE

This notice is effective 18 January 2020.

If you have any questions regarding this NOTICE or the privacy policies of the Health Insurance Portability and Accountability Act (HIPAA) or Family Educational Rights and Privacy Policies (FERPA), please contact this provider.



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Cancellation Policy

Scheduling/cancellations may change at any time in order to accommodate new intake or discharge of clients on therapist's caseloads. We reserve the right to cancel services at any time, for any reason, including but not limited to: Three cancellations within a report period (12 weeks), 2 no call/no shows, repeated cancellations without make ups, lack of compliance with home exercise program (HEP), lack of parent participation in treatment sessions for an extended period of time, or the health and safety of our therapists. Caregiver/Client is responsible for informing therapist within 24 hours of a need to reschedule or cancel and therapist will do the same, unless there is an emergency. If a therapist cancels, we will make every effort to schedule a make up on that therapist's schedule or with another therapist within the company. There are certain times when parents should cancel home visits. Please keep the following guidelines in mind and be sure to contact your therapist as soon as possible.

Some reasons to contact therapist(s) for cancellation:

- A fever of 100 degrees or more
- Had one or more episodes of vomiting within 24 hours
- A generalized rash of unknown origin (not including diaper rash)
- A cold with a lot of mucus discharge (not including allergies)
- Had one or more episodes of diarrhea within 24 hours
- A wound that appears infected (drainage of pus from wound)
- Strep throat (home visits should not be made until 48 hours after treatment has begun)
- Been diagnosed with communicable virus or disease (i.e., Covid-19, conjunctivitis, coxsackievirus, fifth's disease, scabies, head lice, etc.)
- Sibling or other family member suffers from Covid-19, high fever, diarrhea, vomiting, or any other contagious illness or has begun treatment for a communicable disease, but is still considered "contagious" (usually 24-48 hours after treatment has begun or as indicated by your physician.)

We, at It's All Fun Therapy Services, LLP, truly appreciate your understanding regarding these guidelines. Makeup visits will be rescheduled whenever possible in home and/or natural environment.