PATHWAYS PEDIATRIC THERAPY

Welcome! Please take a few minutes to fill out this form completely. Don't hesitate to ask us if you have any questions.

Confidential Patient Information			
Patients' Last Name:	First:	Male Female	
Street Address:	City:	State:	Zip:
Birth date:	School Attended:		Grade:
Does your child currently receive Occupational Therapy: Yes No			
Is it: Group Individual	Does he/she receive any other therapies Yes No		
If yes, please specify: Physical Therapy Speech Therapy ABA Other			

Responsible Party Information			
Parent / Guardian Last Name:		First:	MI
Birthdate:		Employer:	
Marital Status (circle one):	Single	Married Divorced	Other
Home Phone:	Cell Phone:	Email:	
Relationship to Patient:		Spouse:	
Address (if different from above)	Street:		
City:	State: Zip:	Cell Phone:	

Who can we thank for referring our to our office: (please specify name)		
Doctors Office:	School:	Friend/ Family:
Flyer / Brochure:	Insurance Plan:	Internet or self referral:
Will a different caregiver be bringing the patient to therapy? Yes No		
May we discuss treatment with this person? Yes No		
Name:	Relationship:	Cell Phone:

In Case of Emergency:		
Name of a local friend or relative not living at same address:		
Relationship to patient:	Home phone:	Cell Phone:

Confidential Insurance Information		
Is this patient covered by insurance? Yes No	Name of Primary Insurance:	
Insurance Co. Address:		
Insurance Co. Phone:	Patients relationship to subscriber:	
Policy Number:	Group Number:	Co-Payment:
Subscriber Name:	Birthdate:	
Occupation:	Employer:	Address:

935 Trancas St. Suite 5A, Napa, CA. 94558 Tel (707) 258-8011 Fax (707) 224-8124

PATHWAYS PEDIATRIC THERAPY

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Childs Name: ________________________________ Todays' Date:______________

I hereby authorize the exchange of information between Pathways Pediatric Therapy and the following agencies, medical specialists, teachers and/ or therapists.

Doctor: __________________________ School: __________________________

Practice: _________________________ Teacher: _________________________

__________________________________ __________________________________

Phone: ___________________________ Phone: ___________________________

Fax: _____________________________ Fax: _____________________________

Therapist: ________________________ Other: ___________________________

Practice: _________________________ __________________________________

__________________________________ __________________________________

Phone: ___________________________ Phone: ___________________________

Fax: _____________________________ Fax: _____________________________

I do understand that this release and sharing of information will include, but not be limited to conversations, , reports, determinations, evaluations and factual information regarding myself and/or family member(s) who are minors. I understand that this action is taken to assist Pathways Pediatric Therapy in working with me and/or my family.

__________________________ __________________________ ______________

Person Giving Consent Relationship to Child Date

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NOTICE OF PRIVACY PRACTICES

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

USES AND DISCLOSURES

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold rented, transferred, exchanged, and/or used for non-healthcare purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

CERTAIN CIRCUMSTANCES

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

PATIENT RIGHTS

- You have the right to request in writing to inspect and/or receive copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

**Conditions and limitations may apply; obtain additional information from the office.*

CHANGES TO THIS NOTICE: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.