Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Intake Form Date: Location:

Discipline:	☐ Speech Therapy	☐ Occupational Therapy	☐ Physical Therapy	

Patient Information

Last Name:		First Name, Middle Initial:	
Age:	DOB:	Sex: ☐ Male ☐ Female	Grade:

Parent/Guardian Information

Parent/Guardian Name:		Parent/Guardian Name:		
Street Address:		City:	State:	Zip:
Phone #:	Phone #:	Email Address:		

Referral Information

☐ Provider	☐ Internet/Google	☐ Other:

Referring or Primary Care Physician Information

Referring Physician:	Physician Phone #:
Physician Address:	Physician Fax #:
Primary Care Physician:	Physician Phone #:
Physician Address:	Physician Fax #:
When was your last visit to your primary doctor?	Did you discuss therapy with your primary doctor? ☐ Yes ■ No

Have you been treated by another facility in the past calendar year?	☐ Yes	☐ No
If yes, Where?	Facility Phone #:	
Have you been treated by Cole in the last 3 years?	☐ Yes	☐ No

Primary Insurance Information

Insurance Name:	Benefits Phone #:		
ID or SSN:	Group Number:		
Patient's relationship to subscriber:	☐ Self	☐ Child	☐ Other
Subscriber's Name:	DOB:		

Secondary Insurance Information (if any)

Insurance Name:	Benefits Phone #:		
ID or SSN:	Group Number:		
Patient's relationship to subscriber:	☐ Self	☐ Child	☐ Other
Subscriber's Name:	DOB:		

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Patient Name:	DOB:	ID:

General Questions

What would you like me to call you?		
Why are you coming to Cole?		
Has your child ever been diagnosed with anything? If yes, please list.	☐ Yes	☐ No
Do you have a clear understanding of the diagnoses?	☐ Yes	☐ No
Do you participate in any community support groups (social services, school-based services, play groups, church groups)? Please list.	☐ Yes	☐ No
Did you have a healthy pregnancy? (If parent answers no, then ask the following questions) a. Was your child born before 37 weeks? (If earlier than 36-40 weeks please ask at what week child was born) b. Did you have complications during delivery? If yes, could you please give details on the complications?	☐ Yes	☐ No
Does your child have allergies such as latex? Food (eggs, wheat, peanuts)? Environmental?	☐ Yes	☐ No
Does your child have adverse reactions to any drugs? Please list	☐ Yes	☐ No
Is your child currently taking any medication over the counter or prescription? If so, please list medications.	☐ Yes	☐ No

Medication	Adverse Reaction (if any)

Does your child wear glasses? Please bring glasses for appointment. When was your child's last vision exam?	☐ Yes	☐ No
Does your child have difficulty hearing? (If yes then ask the following question) Does your child wear hearing aids or a cochlear implant? If so please bring to the evaluation. When was your child's last hearing exam?	☐ Yes	☐ No
Has your child had a history of seizures? If yes, how often (weekly, monthly, annually)?	☐ Yes	☐ No
Has your child had a recent injury? If so, please bring doctor's release so we are aware of any physical activities the child should/shouldn't do.	☐ Yes	☐ No
Is your child seeing any other doctors or medical specialists (including behavioral therapist)? If so, please list types of doctors and dates of service.	☐ Yes	☐ No
Is your child verbal?	☐ Yes	☐ No
Does your child have any problems eating different foods/is your child a picky eater?	☐ Yes	☐ No
Has your child been exposed to any other language than English? (If so, continue with questions below)	☐ Yes	☐ No
Which language(s) do you speak to your child in? ☐Other_____	☐ English	☐Spanish
Does your child show any of the following behaviors on a regular basis: tantrums, screaming, biting, hitting, kicking, throwing, spitting, and/or pinching?	☐ Yes	☐ No
Does your child show sensory issues such as sensitive to loud noises, light, food, haircuts, brushing teeth?	☐ Yes	☐ No
Can your child sit at the table?	☐ Yes	☐ No
Has your child had an MRI or X-Ray? If yes, please describe.	☐ Yes	☐ No
What are your main concerns?		

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Behavior Questionnaire

Does your child exhibit aggression to the Environment/Property (AE), such as throwing/turning over/ destroying materials)? List behaviors.	☐ Yes	☐ No
Does your child exhibit aggression towards other people? List behaviors (biting, hitting, scratching, etc.)	☐ Yes	☐ No
Does your child exhibit aggression towards self? List behaviors (biting self, hitting self, etc.)	☐ Yes	☐ No
Does your child exhibit verbal aggression towards other people? List behaviors (yelling, screaming, etc.)	☐ Yes	☐ No
Does your child wander away from you?	☐ Yes	☐ No
Does your child drop/fall to ground unexpectedly?	☐ Yes	☐ No
Does your child exhibit ingestion of inedible substances?	☐ Yes	☐ No
Does your child exhibit inappropriate sexual behaviors?	☐ Yes	☐ No
Does your child exhibit grabbing items that do not belong to them?	☐ Yes	☐ No
Does your child exhibit non-compliant behavior? If yes, list inappropriate behaviors.	☐ Yes	☐ No
Does your child respond to student environmental changes (loud noises, people leaving room)? If yes, how do they respond?	☐ Yes	☐ No
Does your child exhibit motor or vocal self-stimulatory behaviors (making noises, hand flapping, or rocking)? If so, what behaviors?	☐ Yes	☐ No

How long can your child remain seated?	☐ Less than 1 minute	☐ Up to 5 minutes	☐ From 5-10 minutes
In a day, how much time is spent engaged in dealing with inappropriate behavior?	☐ Never or between 1-2 times per day	☐ Between 3-4 times a day	☐ More than 4 times a day
How long is your child engaged in inappropriate behavior throughout the day?	☐ Never or less than 1 hour per day	☐ Between 1-2 hours per day	☐ More than 2 hours per day

Additional Notes:

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Patient Name:	DOB:	ID:

Medical History

Has the patient had tubes placement in ears?	☐ Yes	☐ No	If so, when:
Has the patient had any surgeries?	☐ Yes	☐ No	If yes please list type/date:
Has the patient ever been hospitalized or to the ER?	☐ Yes	☐ No	If yes, when and why:

Has your child been diagnosed with any of the following:

☐ Autism	☐ ADD
☐ Down Syndrome	☐ ADHS
☐ Learning Disabilities, Dyslexia	☐ Depression
☐ Seizure Disorder	☐ OCD
☐ Auditory Processing	☐ Social Anxiety Disorder
☐ Schizophrenia	☐ Bipolar
☐ Personality Disorder	☐ Other: _____

Diet/Feeding

Please describe the patient's diet: (check all that apply)	Where does the patient eat? (check all that apply)	Please indicate what items the patient can use: (check all that apply)	
☐ Regular	☐ At the table on a chair	☐ Spoon	☐ Cup (no lid)
☐ Soft foods	☐ Highchair	☐ Fork	☐ Straw
☐ Puree	☐ Booster seat	☐ Knife	☐ Sippy cup
☐ Liquids	☐ Wheelchair	☐ Needs assistance	☐ Bottle
☐ Bolus Feeding	☐ Other:	☐ Other:	☐ Other: _____

Does the patient have special diet needs?	☐ Yes	☐ No	If yes, please describe:	
Does the patient have feeding or swallowing issues?	☐ Yes	☐ No	If yes, Has a swallow study been done?	☐ Yes ☐ No
Can the patient finger feed him/herself?	☐ Yes	☐ No		
If in a wheelchair, is your child positioned upright?	☐ Yes	☐ No		

Developmental / Speech History

Please indicate the patient's developmental history/age:

☐ Crawl	Age:	☐ Sit	Age:
☐ Stand	Age:	☐ Walk	Age:
☐ Use single words	Age:		

Are there any other speech, language, learning, hearing, or mobility problems in your family?	☐ Yes	☐ No

If yes, please describe:

Additional Notes:

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Guidelines to participate in Therapy Services

Welcome to Cole Health! We are looking forward to providing Speech-Language Pathology, Occupational, and/or Feeding Therapy services to your child and working with your family. After reading this information packet, please keep it available for future reference.

1. Please have your child dressed in comfortable clothing that may get dirty during therapy. Play can sometimes be "messy" work and movement activities require comfortable clothing. We will wear aprons during feeding therapy and do our best to keep your child clean, but accidents happen!

2. Treatment sessions are 1-hour for occupational therapy and 30-minutes for speech therapy. Feeding therapy sessions are 30 or 60-minutes. The last few minutes of your child's session will be used to discuss your child's progress in therapy and review any home activities the therapist recommends. Please keep in mind that our therapists have a very busy schedule. Please be respectful of their time by stopping your conversation & questions by the end of the session. If you have additional questions or would like to discuss your child's progress further, please email your therapist directly. If you feel you need a significant amount of time to talk to your therapist, you may schedule a consultation appointment with your therapist.

3. We encourage you to utilize the patient portal where you will be able to check your appointments, for your ease of payment, and view appointment notes from your child's therapy session. All patient balances will be e-mailed to families for payment on Sky Bridge Therapies Online portal.

4. **I**f you are running late for an appointment, please call (253) 201-1234 and let the front desk know OR text us at 253-270-1213. It may be possible to extend your time, or reschedule or a different time, depending on the therapist's schedule; otherwise, your child's therapy session will be cut short by the number of minutes you arrive late to the session.

5. **Parents are to remain on premises at all times.** In the event of an emergency and you need to leave, please advise the front desk. If you choose to remain in your car during your child's session, please return to the lobby 10 minutes prior to the end of session. (We will provide 2 warnings and on the 3rd infraction, patients will be removed from the schedule – i.e., 3 "strikes" rule.)

Signature of Parent or Legal Guardian and relationship	Date

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Patient Bill of Rights

The Patient's Bill of Rights and Responsibilities has three goals:
To strengthen consumer confidence that the health care system is fair and responsive to consumer needs; to reaffirm the importance of a strong relationship between patients and their health care providers; and to reaffirm the critical role consumers play in safeguarding their own health. The Commission articulated seven sets of rights and one set of responsibilities:

The Right to Information:
Patients have the right to receive accurate, easily understood information to assist them in making informed decisions about their health plans, facilities, and professionals.

Being a Full Partner in Health Care Decisions:
Patients have the right to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parent, guardians, family members or other conservator. Additionally, provider contracts should not contain any so-called "gag clauses" that restrict health professionals'' ability to discuss and advise patients on medically necessary treatment options.

Care without Discrimination:
Patients have the right to considerate, respectful care from all members of the health care industry at all times under all circumstance. Patients must not be discriminated against in the marketing or enrollment or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law, based on race, ethnicity, national origin, religion, sex, age, current, or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.

The Right to Privacy:
Patients have the right to communicate with health care providers in confidence and to have the confidentiality of their individual-identifiable health care information protected. Patients also have the right to review and copy their own medical records and request amendments to their records.

The Right to Speedy Complaint Resolution:
Patients have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

Taking on New Responsibilities:
In a health care system that affords patients' rights and protections, patients must also take greater responsibility for maintaining good health.

Complaints and Appeals:
If you have questions or comments regarding the Patient Bill of Rights, please contact President, Jason Stark, or his designee, when the President is not available.

To reach the President, please write or call the following location:
16835 Deer Creek Dr. Ste. 200
Spring, TX. 77379
281-379-4373

Grievance Procedure
By my signature below, I hereby acknowledge that I have been informed of Cole's Grievance Procedure which is prominently displayed throughout the clinics and I have been informed that all grievances are taken seriously, investigated promptly and a response is provided by the appropriate manager at Cole Health. In order to register my grievance, I can request that a grievance be initiated from any Cole Health Employee and the concern will be forwarded to the appropriate manager for investigation. I have also been informed that the contact information for outside representatives is prominently posted in each clinic.

Signature of Parent or Legal Guardian and relationship	Date

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Patient Name:	DOB:	ID:

Comprehensive Treatment Plan Agreement

It is understood that Cole Speech & Language, Cole Consolidated, Northeast Rehab, Cole ABA Solutions (DBA Cole Pediatric Therapy, Cole Rehabilitation, and Cole Academy), Cole Sky Therapy PLLC, Cole Health Management Services LLC, Cole Coastal Therapy LLC, Cole District of Columbia LLC, hereinafter will be referred to as Cole Health.

In order to provide the best services for our patients, we ask you to please read and acknowledge that you agree to abide with the policies outlined by signing where indicated. These policies are effective September 1, 2005. If you have any questions about these policies, please ask a representative of this center before signing.

Acknowledgement of Receipt

- I have received and have had the chance to have explained, the Patient Bill of Rights.

Acknowledgement of Risk

- I understand that there is some risk inherent in the use of therapeutic equipment at this Center, and I agree to indemnify and hold the center harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment.
- If you/your child is receiving therapy via Telehealth:
  I understand that there are potential risks to the use of this technology, including but not limited to interruptions, authorized access by third parties, and technical difficulties. I am aware that either my/the patient's therapist or I can discontinue the telehealth service if we believe that the videoconferencing sessions are not adequate for the situation.

Advance Directives

☐ I have or ☐ I have not signed a ☐ Living will Advanced Directive or ☐ Out of Hospital DNR. ☐ I am ☐ I am not providing a copy for my record.

Medical Power of Attorney: **Telephone Number:**

Agreement to the following Code of Conduct and Responsibilities

- Behavior that shows respect and consideration for other patients, family, visitors, and personnel of the Center.
- In order to receive maximum benefit from therapy, it is important for therapy to occur every day and I am responsible for ensuring my child is available at the designated time. If for any reason I cannot be present for any visits in a timely manner, I am responsible for promptly notifying Cole Health and following the guidelines as outlined in the cancellation policy.
- I am responsible for learning and following through with techniques and activities presented to me in order to complete my child's treatment plan.
- I understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and monitoring my child's play in the waiting room.
- If applicable, I understand that the Center prefers I wait during the session if not participating so that I am able to monitor some of my child's treatment when appropriate. I understand that it is the policy of this Center that a parent or legal guardian must remain in the Center during treatment sessions unless other arrangements have been, and we have an emergency contact number.
- I will know how to contact my child's physician and comply with his/her instructions.
- I will keep Cole Health. informed of any changes in my child's medical care including hospitalizations or emergency room visits.
- I will keep Cole Health. informed of any changes in my child's insurance benefits as soon as I am aware of them to avoid services being placed on hold.

Complaint or Grievance Policy

- I understand that should I have a complaint, I am to report it to the office immediately. If you feel the complaint isn't resolved satisfactorily or in a timely manner you may contact the Director.

Non-Discrimination Policy

- Cole Health does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy contact the Director.
- Speech, Hearing (Relay Texas) and Visual assistance communication guides are available at no charge and upon request. For further information about this policy, contact the Director.

Speech, Occupational, and Physical Therapy Scheduling Policy and Consent to Treat

- I hereby consent to treatment services and understand that once an appointment schedule has been established, the Center may not be able to accommodate short term scheduling changes. When a permanent change in time is needed, I must give as much advanced notice as possible for the Center to attempt to accommodate this request. A change in time may necessitate a change in therapists. Most therapy sessions are based on 30-50 minute treatment session followed by a five (5) to ten (10) minute conference with the parent/guardian. Late arrival for an appointment may result in a shorter therapy session or cancellation of the therapy session.
- I understand that the Center is open from 8 a.m. to 8 p.m. Monday through Friday and Saturday through Sunday from 8 a.m. to 6 p.m. however, hours vary by location. During times of severe weather, it is my responsibility to call the Center to determine whether changes in the scheduled time of treatment are needed or if the opening of the Center has been delayed. Families may reschedule treatment if they do not wish to travel in poor weather conditions. I understand that if treatment time falls on a holiday that I am encouraged to make up these sessions.
- I understand that if our therapist is ill or on vacation, the Center will provide a substitute therapist to ensure continuation of services. The Center will make every effort to schedule the therapist at your regularly scheduled appointment time. If this cannot occur, the Center will provide an alternate appointment time.

The undersigned certifies that they have read the foregoing, received a copy thereof, agree to abide by and is the patient or patient's legal guardian to execute the above and accept its terms.

Signature of Parent or Legal Guardian and relationship	Date

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Patient Name:	DOB:	ID:

Consent form for Telehealth Agreement

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform. I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective. I understand that there are potential risks involving technology, including but not limited to: Internet interruptions, and technical difficulties.
I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my username and password and not share these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if it is felt that this type of service delivery does not benefit my needs. I have read and understand the information provided above regarding telehealth or teletherapy, have discussed it with my health care provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth or teletherapy in my care.

Signature of Parent or Legal Guardian and relationship	Date

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Patient Name:	DOB:	ID:

Financial Responsibility

In consideration of services rendered or to be rendered to the patient, the undersigned, hereby obligates himself/herself individually and agrees to pay for any and all charges incurred for therapy and/or behavior treatment services. It is agreed and understood that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to Cole Health and I agree to pay for any and all charges and expenses incurred. I also understand that as the financially responsible party, I am accountable for the remaining balance not covered by the insurance company. I understand that I am declining my right to do a predetermination of benefits, unless noted below. Predetermination of benefits usually takes from 45 to 60 days before we know if the insurance company will cover treatment services, treatment spots may not be held during this time. In some cases, doing a predetermination of benefits is not applicable and is not a guarantee of payment from the insurance company. I understand that Cole Health will work as quickly and efficiently as possible with my insurance provider; however, I will be financially liable for all services not covered by my health plan. While the responsible party is liable for the total charges for services rendered, Cole Health will abide by any contractual limitations included in insurance agreements that limit certain collections.

It is further agreed and understood that should this account become delinquent, and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I as the designated responsible party, shall pay all therapy charges, reasonable attorney's fees, and collection expenses. I understand that at $35 fee will be incurred on each returned check. If I do not call before my appointment to cancel/reschedule, I understand that I could be charged, when applicable, and will incur an unexcused absence.

Assignment of Benefits to Clinician
In consideration of therapy and/or behavior treatment services rendered, I hereby assign and transfer to Cole Health all right, title, and interest in all benefits/monies payable for treatment services by my medical insurance coverage. It is hereby agreed and understood that any condition precedent, subsequent or otherwise, including, but not limited to, preauthorization, or predetermination shall remain the sole responsibility of client's designated responsible party. I further understand that failure to pre-certify could result in reduced payments from client's insurance co., leaving the undersigned financially responsible for the non-reimbursed portion of patient's bill.

Authorization to Appeal
I hereby authorize Cole Health to appeal on behalf of the patient's claim(s) with my insurance company, if applicable, and/or payer which denies and/or delays payments of my claim(s).

Payment for Services Agreement (This does not apply to clients with Medicaid)
I hereby agree to submit payments in full when services are provided, unless otherwise agreed upon and noted below. I understand that statements will be sent out by Cole Health at the beginning of each month, and I agree to remit payment no later than the 15th of each month. I understand that co-payments will be made even during the time that I am paying towards my deductible, and that Cole Health will send me a statement at the beginning of the month with the remaining balance. I understand that Cole Health will be filing the insurance claim forms in my behalf and that I may contact Cole Health at 281-379-4373 if I have any questions regarding my bill or insurance reimbursement.

When filing with your insurance company, Cole Health will review our current rates with you. If we do not use your insurance and you pay at the time of service, cash pay rates are available.*Rates are subject to change with notification.

I understand that I must call Cole Health at 253-201-1234 before the initial assessment to get the insurance information in order. Any changes in insurance policies or companies must be immediately reported to Cole Health. Failure to notify Cole Health of any changes may result in disruption of therapy services or parental responsibility for payment

The undersigned certifies that they have read the foregoing, received a copy thereof, agrees to be bound to the terms and fees within and is the patient or patient's legal representative to execute the above and accept its term.

Signature of Parent or Legal Guardian and relationship	Date

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Patient Name:	DOB:	ID:

HIPAA Compliance

I understand that as part of the provision of healthcare services, Cole Health creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

By my signature below, I acknowledge I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their Notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services, and auditing functions, etc.). The organization is not required to agree to the restrictions requested.

By signing this form, I consent and authorize clinicians with Cole Health to disclose treatment records, assessment reports, progress notes and any other information necessary to the patient's school, physician, behavioral therapist and/or any other person or entity that would assist in behavior therapy program, payment, and health care operation. I have the right to revoke this consent, in writing, except where disclosures have already been made on my prior consent.

I further understand that using any video or audio recording device while in the clinic is strictly forbidden. Use of any video or audio recording device while in the clinic violates HIPAA Privacy Laws and you, in addition to the clinic, could be personally liable for this violation.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have had the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment, payment, or health care operations, be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

Can we contact other family members or other individuals about the patient's general information & diagnosis?	☐ Yes	☐ No

If yes, please list whom we may inform about the patient's general information and diagnosis (including treatment, payment and health care operations):

Can we contact family members or other individuals about the patient's medical condition only in an emergency?	☐ Yes	☐ No

If yes, please list name, relationship, and phone number:

Name:	Relationship:	Phone Number:

The undersigned certifies that they have read the foregoing, received a copy thereof, and is the patient or patient's legal representative to execute the above and accept its terms.

Signature of Parent or Legal Guardian and relationship	Date

Cole Health
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16835 Deer Creek Drive
Suite 220
Spring, TX 77379
(281) 379-4373
www.colehealth.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

▶ **See page 2** for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition

▶ **See page 3** for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

▶ **See pages 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • File a complaint by contacting ***compliance@colehealth.com*** or calling ***281.290.4380*** • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ • We will not retaliate against you for filing a complaint.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Cole Health and its associated entities do not create or manage a patient directory.
Cole Health and its associated entities do not create or maintain psychotherapy notes at any of its locations.

The Texas Medical Privacy Act is much more restrictive of marketing than HIPAA is. HIPAA allows covered entities to market virtually all types of health products, with a few restrictions, without obtaining authorization from the individual. The Texas Medical Privacy Act prohibits any release of PHI for marketing purposes without consent or authorization from the individual. Texas Medical Privacy Act §181.152(a),(b),&(c).

The North Carolina Statutes relating to HIPAA and Patient Privacy provide for Communicable disease reporting in § 130A. This section allows the reporting of communicable disease by physicians, school principals and child care operators, medical facilities, and food and drink establishments.

The District of Columbia has enacted the Security Breach Protection Amendment Act of 2020 ('the 2020 Breach Amendment'), which updated DC's breach notification law. The 2020 Breach Amendment, took effect in June 2020, and added several major changes to DC's breach notification law, codified under §§28–3851 et seq. of Subchapter II of Chapter 38 of Title 28 of the Code of the District of Columbia ('D.C. Code') ('the Breach Notification Law'), first enacted in 2007.

Washington State HIPAA Breach Notification Act requires healthcare organizations to report breaches that compromise the confidentiality, integrity, or availability of protected health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 09/01/2022

This Notice of Privacy Practices applies to the following organizations.

Cole Health is part of an OHCA (organized health care arrangement) that has agreed to a joint notice for the following entities: Cole Pediatric Therapy; Cole Speech & Language Centers, LP; Cole Health, Inc., Cole Consolidated Rehab, LLC; Cole Costal Therapy, LLC; Cole Sky Therapy, PLLC, Cole Health Management Services, LLC; Cole District of Columbia, LLC; Cole ABA Solutions, Inc., and Cole Academy. Cole Health shares information within the OHCA for treatment, payment and operations related to the OHCA. This notice applies to all the above entities located in Texas, North Carolina, Washington and Washington DC which operate Outpatient Pediatric Therapy Clinics and Applied Behavior Analysis Therapy. This notice applies as well to the Clinics located in North Carolina and Washington, DC who also do in-school therapy visits.

Privacy concerns can be reported to Jason Stark, President of Cole Health Entities at Jason.Stark@colehealth.com or Cole Corporate Compliance Department at Compliance@Colehealth.com.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Patient Name:	DOB:	ID:

Child Release

Emergency Contact and Authorization/Consent for Transportation of Child by Others

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child, if I cannot be reached; I understand that the emergency contacts (listed below) will be called. However, I hereby authorize Cole Health to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. Payment for emergency services will be the responsibility of the parent(s)/ legal guardian(s).

To ensure children's safety, Cole Health will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below as undersigned by the parent(s)/legal guardian(s). Parent(s)/legal guardian(s) who sign the form do not need to be listed on the form. Please include the name of at least one local person who is not your child's parent/legal guardian to whom Cole Health could release your child in an emergency.

Name:								
Relationship:								
Day Phone:								
Evening Phone:								
Address:								
City, State, Zip:								
Emergency Contact:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Authorized to Transport:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Date:								
Name:								
Relationship:								
Day Phone:								
Evening Phone:								
Address:								
City, State, Zip:								
Emergency Contact:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Authorized to Transport:	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Date:								

By signing this form, I recognize that Cole Health will not release my child to any other person unless I notify the Cole Health in advance, following the guidelines listed blow:

- If the person picking up my child is NOT listed on this form I must notify the clnic in writing.
- Photo identification will be required of any person picking up my child.

Signature of Parent or Legal Guardian and relationship	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Medical Records Obtain/Release	
Patient Name:	**DOB:**
ID:	**SSN:**
Authorization to OBTAIN records: I authorize Cole Health to **OBTAIN** medical record information to include x-rays, reports, clinical lab studies, progress notes and any other pertinent information that would assist in the continuity of medical care and treatment for the patient listed above.	
Pediatrician or Primary Care Physician:	
Address:	
Phone Number:	Fax Number:
Other Physician:	
Address:	
Phone Number:	Fax Number:
Authorization to RELEASE records from Cole Health, please allow one week for medical records to be sent to the above named party: • I authorize Cole Health to **RELEASE** medical record information to include x-rays, reports, clinical lab studies, progress notes and any other pertinent information that would assist in the continuity of medical care and treatment for the patient listed above. • I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for the following: conducting research-related treatment; obtaining information in connection with eligibility or enrollment in a health plan; determining an entity's obligation to pay a claim; or creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records. • I may revoke this authorization at any time, provided that I do so in writing and submit it to Cole Health, 16835 Deer Creek Drive Suite 200 Spring, TX. 77379. The revocation will take effect when Cole Health receives it, except to the extent that Cole Health or others have already relied on it. • I am entitled to receive a copy of this authorization. **Expiration of Authorization** • Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form. **Complaints** • Any or all complaints can be directed to the Privacy Officer at Cole Health, 16835 Deer Creek Drive, Suite 200, Spring, TX, 77379	
Other:	
Address:	
Phone Number:	Fax Number:
Other:	
Address:	
Phone Number:	Fax Number:
Signature of Parent or Legal Guardian and relationship	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Patient Name:	DOB:	ID:

Medical issues that may result in Cancellation/Reschedule

Hand washing and practicing Universal Precautions are the best way to prevent the spread of an infection.

Medical Issue	Cole Health Policy
Appearance of Rash, Wound, or Lesion	• If rash is accompanied by a fever, it is recommended to reschedule the appointment • Gloves must be worn for any skin irritation with drainage and/or red elevated areas • All equipment used in treatment session must be disinfected • Gloves must be worn while working with any open wound that cannot be covered
Fever	• If child has a fever of 100.5 degrees or higher, it is recommended to reschedule the appointment • If the child has a fever between 98.6 and 100.5 but also showing other signs and symptoms of an infection, it is recommended to reschedule the appointment • Child must be fever free for 24 hours prior to returning to Cole Health.
Eye Infections	• If the child has been diagnosed with Conjunctivitis (pink eye) and has not been on antibiotics for 24 hours, it is recommended to reschedule the appointment • All universal precautions must be used by the therapist
Cough, Congestion or Drainage	• If the child shows signs of a productive cough or runny nose (accompanied with yellow/green mucous and a fever) and it is within the first 48 hours of antibiotics, it is recommended to reschedule the appointment
Lice	• If the child currently has lice (live bugs or nits), it is recommended to reschedule the appointment for when the lice has been adequately removed
Vomiting	• Multiple episodes within the last 24 hours
Diarrhea	• More than 3 episodes in a 24-hour period
Diseases	• Strep Throat, mononucleosis, chicken pox, influenza, measles, rubella, bacterial meningitis, mumps, whooping cough, scarlet fever, and Tuberculosis.

Signature of Parent or Legal Guardian and relationship	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Patient Name:	DOB:	ID:

Attendance Policy (Physical, Occupational, Speech Therapy)

Your child's attendance is critical to their overall progress and ability to achieve their goals. In order assure they are reaching their full potential, we ask:

- Please arrive early for your scheduled appointments. If you think you may be late, please contact the clinic immediately.
- We encourage you to not leave the premises, if you must please provide a working phone number.
- If you need to reschedule an appointment, you must do so **AT LEAST 24 hours BEFORE** the scheduled appointment time. A cancellation of less than 24 hours of the appointment time will be considered a **No Show**. **A $35 charge will be billed to the family for any cancellations within 24-hours of an appointment.** I understand that I will be given 1 opportunity to reschedule and if I cancel or no-show that appointment, I will be charged the no-show fee. The fee must be paid before the child's next session.
- No shows are when you fail to call to cancel and/or do not show up to the appointment, or if you cancel within 24 hours prior to the appointment time. After **2 No Shows** (with no phone call or with phone call to notify less than 24 hours), your child will potentially be removed from the schedule.
- If there are more than 4 cancellations that are **NOT made up**, your child will potentially be removed from the schedule due to non-compliance with attendance. Your child's primary care physician will be notified.
- If you know you are going to be out of town, please let us know as soon as possible so that any missed sessions can be rescheduled ahead of time.
- Excessive absences can prevent progress for the child, as all children do better with consistency! Absences may also result in therapy sessions not being covered by insurance or Medicaid.

Sick Policies

- If you or your child is sick, please reschedule your appointment as soon as you know. (The 24hour cancellation policy also applies for illness). We ask that you not to bring a child to therapy until they have been fever FREE for at least 24 hours. This will prevent spreading the illness to other children.
- If you are unsure whether your child should be seen for therapy, please contact the office right away.
- If the child's appointment is canceled (whether canceled by the caregiver or clinician), the missed sessions should be rescheduled.
- If the therapist is ill or out of office, we will attempt to reschedule your appointment with another clinician during the regular appointment time. If this is not possible, an alternate appointment time will be offered.
- Make-up appointments are not guaranteed to be with the regular treating therapist.

Permanent Schedule Changes
In order to maintain consistency and progress with your child, we strongly discourage frequent schedule changes. We will accommodate **1** permanent schedule change in a six-month period. **Saturday/Sunday Appointments (if applicable)** Due to a growing need on Saturdays/Sundays, it would not be fair to hold open appointments for patients who do not show or frequently cancel. Therefore, Cole Health's policy for Saturday/Sunday appointments is a patient may be removed from the Saturday/Sunday schedule if (1) "No Show" occurs however, your child is allowed 1 cancellation per 3-month period.

Telehealth
Speech, Occupational, and Physical Therapy may also be available through Telehealth, depending on your payer source. Telehealth is innovative online therapy that is customized to meet the needs of your child.

If you must cancel or reschedule an appointment, please contact Cole Health as soon as possible at:
Phone: (253) 201-1234
Text: (253) 270-1213

Signature of Parent or Legal Guardian and relationship	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Patient Name:	DOB:	ID:

Teletherapy Policy

Extenuating circumstances may occur that require the need to switch an in-person session to a teletherapy session at the last moment; however, in order for our therapists to have adequate notice to prepare and plan for a virtual session for your child, we require a minimum of 1-hour notice.

If you are unable to provide at least 1-hour notice, we will unfortunately have to cancel your appointment and you will be charged the $35 no-show fee, unless you are able to reschedule to another day in the week.

Vacation Policy

Patients who have consistent, regular attendance over the past quarter (i.e. no poor attendance warnings and no erratic or inconsistent attendance over the past quarter) can miss up to 2 WEEKS [and keep their regular time slot(s)] if they provide the clinic with at least 1-month notice.

This allows Cole Health sufficient notice to plan staffing accordingly. If you have any questions regarding attendance, please call us at (253) 201-1234 or text us at (253) 270-1213.

If you are traveling within the state of Washington, we strongly encourage your child to participate in teletherapy while away in order to maintain consistency with their therapy goals.

Signature of Parent or Legal Guardian and relationship	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Patient Name:	DOB:	ID:

Video and Audio Monitoring Policy

Video monitoring is used in the therapy rooms and hallways. In addition, Cole Health uses video and audio monitoring to maintain the safety and security of clients, families, and staff.

Placement and Notification

1. Video/Audio monitoring equipment may be installed in the Cole Health therapy rooms and hallways where there is a legitimate need for video monitoring.
2. Video/Audio monitoring equipment will not be used or installed in areas where the public, clients, families, and/or staff have a reasonable expectation of privacy such as changing rooms and bathrooms/restrooms.
3. Our current system operates and records when motion is detected in the area and does not record unless motion is detected. Currently some Cole Health's camera systems use video/audio monitoring combinations, and some centers only use video monitoring. Cole Health reserve the right to continue video/audio monitoring using any updated system as may be deemed reasonable and available as new technology emerges and becomes available.
4. Video/Audio monitors shall not be located in an area that enables public viewing.
5. Conduct and comments in publicly accessible places on Cole Health property may be recorded by video and/or audio devices.
6. Cole Health will notify clients, families, and staff that Video and/or Audio monitoring systems are present. Such notification will be included in staff handbooks, client admission packets, and signs will be prominently displayed in appropriate locations throughout Cole Health.
7. Specific notification will not be provided when a recording device has been installed or upgraded, or when it is being utilized in a particular Academy.

Use of Video and Audio Monitoring

1. The use of Video/Audio monitoring shall be supervised by the Director of Cole Health.
2. Staff, clients, and families are prohibited from unauthorized use, tampering with, or otherwise interfering with audio or video recordings and/or video camera equipment. Staff, clients, and families are prohibited from using any personal type of audio or video devices while in the clinic. Violations will be subject to appropriate disciplinary or legal action.
3. Cole Health may use video/audio monitoring for any lawful purposes, including but not limited to, reasons of safety for staff or clients, or in determining the therapies set forth in the individualized patient care plan are having the desired effect, or if the patient care plan needs to be modified with new interventions.

Storage and Security

1. Cole Health shall provide reasonable safeguards including, but not limited to password protection, well-managed firewalls and controlled physical access to the video/audio monitoring systems to protect the monitoring system from hackers, unauthorized users, and unauthorized use.
2. Video/audio recordings will be stored for a minimum of 10 days after the initial recording. Due to the limited amount of storage, if the Director knows of no reason for continued storage, such recordings will be erased.

Signature of Parent or Legal Guardian and relationship	Date

Cole Health
PEDIATRIC THERAPY | ABA SOLUTIONS

Patient Name:			**DOB:**			**ID:**	
Payment Authorization Form							
Cardholder Name (as shown on card):							
Billing Address:							
Mastercard	☐	Visa	☐	AmEx	☐	Other	☐
Card Number:			Expiration Date (MM/YY):			CVV Code:	

Payment amount will vary based on services rendered and any additional fees that may apply.

I, _____, authorize Cole Health to charge the credit card above for agreed upon services. I understand that my information will be kept on file to process future transactions for services rendered and any additional fees that may apply.

I understand that Cole Health will charge my card on or before the 3rd Wednesday of the month for any outstanding balances unless otherwise notified. Cole Health must be notified of any changes to the method of payment.

Signature of Cardholder	Date