Welcome to Milestone!

We are thrilled to be providing therapy services for your loved one! Our Clinic is located In Chandler at 600 W. Ray Rd. in Suite D-1, which is on the north side of Ray between Arizona Ave. and Alma School. We are on the North West corner of Hartford and Ray. Enter the courtyard and we are in suite D-1. If your child/loved one will be seen in the clinic, please be sure to arrive five to ten minutes before the scheduled appointment time so we may collect your paperwork.

Please fill out the following documents and return them to our offie as soon as possible so that we are able to serve you. You may also elect to bring them with you to the clinic for the evaluation or first visit. As you may already be aware, **we must get authorization from DDD before starting services**. Please contact your coordinator if you haven't done so already.

Document List:

1. Enrollment Form (Pre-Service Orientation)
2. Occupational Therapy Questionnaire *(for Occupational Therapy Clients only)*
3. Insurance Information Form
    a. Copy of the front and back of Insurance Card(s)
4. Consent to Treat and Bill
5. Release of Confidential Information
6. Patient HIPPA Awareness Agreement
7. Client Rights
8. Acknowledgement Form
9. Cancelation Policy

Please keep for your records:

1. Privacy Practices
2. Cancelation Policy (Family Copy)

Please mail or bring with you the competed documents to:
Milestone Pediatrics
600 W. Ray Rd. Ste D-1
Chandler, AZ. 85225

Important Notes:

1. Therapy sessions are 50 minutes in length and you will be asked to sign a form at the end of each visit.
2. It is important for caregivers participate in therapy sessions.
3. You MUST stay at our facility or your home for the entire therapy session.
4. It is important to keep scheduled visits, otherwise it may impact continued services.
5. Your Therapist(s) will be providing you with home program recommendations. It is important to incorporate these in your daily routine to get the most out of therapy sessions.
6. Milestone is committed to quality service and we welcome your feedback! Please don't hesitate to contact us with questions or concerns.

Welcome to Milestone!

Lyndsey Steele
Owner/Co-Founder
Program Director

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NOTICE OF PRIVACY PRACTICES

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.

Our commitment to your privacy:
Milestone Pediatrics, LLC.. is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, so please feel free to contact us with any additional questions.

Summary of Privacy Practices:
As of April 14, 2003, new federal laws mandated in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). HIPPA is concerning patient privacy and access to medical records. The purpose of this document is to provide you information on how the law impacts you.

Patient's Rights to Access Records:

- You have a right to request to see your records or to request a copy of your records. Upon receipt of your written request, our office will contact you to make arrangements to review your records in the ASMC office or to copy the records you have requested.
- You have a right to request a written summary or explanation of your records. Upon receipt of your written request, our office will arrange to send you your records.
- Your have a right to inspect and to request an amendment to your records. If, in reviewing your records, you find an inaccuracy in the facts documented or an omission, you have the right to submit an amendment to your record.
- You have a right to request a limited accounting of disclosures of your records. You may request an accounting of any disclosures of your health information to purposes other than treatment, payment, or healthcare information.

Rights to Privacy:

- You may request additional protections for sensitive health information or to limit disclosures of portions of your health information.
- In addition to the protections for Highly Confidential Information specified by HIPPA, you may request, in writing, that other sensitive information be protected. Our office will take steps to implement these protections and to inform you of the limits of these steps.
- You have a right to request that your personal health information be communicated to you in a different manner or at a different location. You must make this request in writing.

Rights of Parents of Minor Children:
As a parent or guardian of a minor child, you have the same rights of access to your child's records as to your own, with the following exceptions:

- Your rights to access of the minor child's medical records have been revoked or limited by a court of law.
- Your minor child is an emancipated minor under the law.
- Services are provided to your child under the regulations of the State of Arizona.

Your Responsibilities Under HIPPA:
In order to safeguard your rights under HIPPA, you have a responsibility to keep Milestone Pediatrics, LLC.. informed of any changes that would affect the disclosure of your personal health information. You have an obligation to:

- Provide accurate information about your address, telephone number, and insurance coverage each time you visit.
- Report any changes in your personal health representative, emergency contact information, and structure of your family, etc.
- Respect the privacy rights of your patients.

Milestone Pediatrics, LLC.. Responsibilities:
Our first responsibility, as always, is to safeguard the health of our clients. If we believe any of the provisions of HIPAA could endanger your life or physical safety or that of another individual, the practice must act in accordance with this belief and do what is in the best interest of the client.
We are also responsible for safeguarding your privacy. We have an obligation to keep you informed of any disclosures of your personal health information outside of those required for treatment, payment of services, and healthcare administration.

We also have an obligation to work with you to ensure your rights under HIPAA. Our office will work directly with you to ensure your rights to privacy and to access under HIPAA. Any client believing his or her privacy rights have been violated may file a complaint with our office. A complete copy of your privacy policy can be obtained from our Client Services Manager. Milestone Pediatrics, LLC.. reserves the right to change the terms of this notice and to make the new terms apply to all protected health information it maintains. Our Program Director can be reached at (480) 855-0474.

MILESTONE PEDIATRICS CANCELLATION POLICY
(Family Copy)

Please review the cancellation/no-show policy. Our goal is for your child/loved one to have a successful and rewarding therapy experience. Consistency is essential in order to provide your child/loved one with the best chance of achieving his or her treatment goals.

NO-SHOWS
Our therapists are in great demand, and as a result, we are unable to accommodate individuals that have repeated no-shows. No-shows are defined as cancellations with no notice or less than 24 hours notice**. IF CANCELLATIONS AND/OR NO-SHOWS ARE IN EXCESS OF 2 no-shows in a quarter or within a four week period, YOUR CHILD/LOVED ONE MAY BE AT RISK FOR BEING DISCONTINUED from therapy services and will contact the parent/guardian and support coordinator (if appropriate) to problem solve the reason for the frequent no-shows.**

50% Policy
We understand that many times, health issues of the child/loved one or family emergencies may cause a client to miss several appointments in a quarter. We will attempt to be accommodating in these situations. We are unable to commit therapy slots to individuals who are not available on a regular basis. If 50% of the visits in a quarter are no-shows or client cancellations, we will need to make appropriate changes to our delivery of therapy services. Options that would be available include changing the day and time slot-dependent on the therapist's availability, decreasing the frequency of services, placing the client on-hold, or discharging the client from the services and/or from our agency. These options would be discussed with you and when applicable, with your support coordinator.

Therapist Cancellations
From time to time, our therapist may need to cancel their appointment. We will do our best to give the family at least 24 hours notice. In the case of an emergency, the cancellation may need to be made with less than 24 hours notice. The therapist will do their best to re-schedule the appointment.

If you do need to cancel your therapy, please call at least 24 hours prior to your scheduled appointment time. It is best to arrange a make-up session with your Therapist that week.

For the fairness of your Therapist and other families they work with, please cancel your therapy appointment if your child/loved one is sick (including a fever, diarrhea, or vomiting) within the last 24 hours, or has pink eye, or any other contagious condition.

If your child/loved one will be unavailable for three consecutive therapy sessions (due to extended vacation, surgery, hospitalization), the appointment time cannot be guaranteed to be held and could be at risk for being discontinued.

CLINIC BASED SERVICES:
In the event that you running late to the scheduled visit, please call the therapist/office to notify. Due to scheduling of other clients, the therapist can't extend a session if you arrive late. This means the 50 minute visit will be cut short. If you arrive more than 10 minutes late, you will be asked to skip or reschedule (if possible) the visit. After two late or missed visits per quarter, the reserved ongoing timeslot will no longer be guaranteed and will be opened up to another client.

A parent/caregiver over the age of 18 must be present to PARTICIPATE during all therapy sessions. You cannot leave the premises while your child/loved one is in therapy.

Remember to call your therapist directly any time you need to discuss your child's/loved one's therapy schedule.

Speech/Occupational Therapy Enrollment Form

Pre-Service Orientation

TODAY'S DATE: ________________
Which service are you enrolling in? _____ Speech Therapy _____ Occupational Therapy

CRITICAL INFORMATION:

Client's Name: ________________________________ Dob: ______________ Age: ______ Sex: **M / F**
Home Address: ___________________________________ City: _________________ Zip: _____________
Primary Contact Person: _______________________________ Relationship to Client: ___________________
E-Mail: __________________________________
Preferred Method of Contact: Phone ☐ Text Message ☐ Email ☐
Mother/Guardian Name: ____________________________ Age: _________ Occupation: _________________
Phone #: Home (_____) _____________ Cell (_____) _____________ Work (_____) ______________
Father/Guardian Name: ____________________________ Age: _________ Occupation: _________________
Phone #: Home (_____) _____________ Cell (_____) _____________ Work (_____) ______________
Is the Primary Caregiver's address the same as above? ______Yes______No
(If No, Please List Address) ____
Emergency Contact: ______________________ Phone (_____) ___________ Relationship: ______________
Who Is Your DDD Support Coordinator: ______________________________ Phone: (______) ____________
Primary Care Doctor: ____________________________ Doctor's Phone #: (______) _____________
Urgent Care or Hospital name and location *(In Case of Emergency):* _____________________________________
How did you hear about Milestone? ____

FAMILY MEMBERS LIVING AT HOME:

Name	Age	Relationship	Name	Age	Relationship

HEALTH:

Diagnosis/Medical Concerns:____
Allergies *(list all food and environmental allergies)*: ____
Special Dietary Needs:____
Seizures: ______YES ______NO *(if yes, please describe)*: ____
Current Medications *(list name, dosage, frequency, route, and purpose)* _____ N/A

____

____

Adaptive Devices/Equipment *(communication, protective, and/or mobility devices)* _____ N/A

____

____

PREGNANCY/BIRTH:

Length of pregnancy (#of weeks): ___________________ Birth Weight _____lbs _____oz

Type of Delivery: ___________________

(Check and explain if any of the following were present)

____Injuries or disease or mother during pregnancy
____Bleeding (if so, when?)
____Toxemia
____Maternal alcohol or drug abuse
____Any other information that may be pertinent to this pregnancy

____Any difficulties at delivery (please explain)
____Mother need medication (if so, what
____Difficult birth (please explain)
____Cord around neck
____Baby needed oxygen
____Baby had respiratory distress
____Baby was jaundiced (yellow)
____Baby was premature

Please explain: ____
____
____
____

GENERAL HEALTH:

Last Vision Screening (date): __________________________ Results: ____________________________

Does your child/loved one wear glasses? _____YES _____NO Contact lenses? _____YES _____NO

Last Hearing Screening (date): __________________________ Results: ____________________________

Does your child/loved one wear a hearing devise? ____YES____NO If yes, explain:_________________

History of Ear Problems? ______YES ______NO If yes, explain:_______________________________

Any serious illnesses or hospitalizations? ______YES ______NO

If yes, explain:____

MEDICAL HISTORY:

Has your child/loved one been diagnosed with, treated for, or exhibit signs of (*please check all that apply*):

	Medical		**Emotional**
______	Asthma	______	Anger/Outbursts
______	Attention problems	______	Attention Problems
______	Cleft lip/palate *(specify)*	______	Depression
______	Encephalitis	______	Easily Frustrated
______	Head injury *(please explain)*	______	Extreme Shyness
______	Heart Disease *(specify)*	______	Hyperactivity
______	High Fevers	______	Impulsivity
______	Meningitis	______	Self-Abusive Behavior
______	Seizure Disorder	______	Violent Behavior

Please explain: ____
____
____
____

DEVELOPMENTAL HISTORY:

At what age did your child/loved one:

Roll over _______, Sit Independently_______, Crawl _______, Walk _______, Babble _______, Say First Words _______, Use Two Words Together _______, Pureed Foods _______, Finger-Feeds _______, Uses Utensils _______, Stopped Bottle Feeding _______, Used a Sippy Cup _______, Used a Straw Cup _______, Used an Open Cup _______, Dressed Independently _______, Day-Time Potty Trained _______, Night-Time Potty Trained _______.

What concerns do you have about your child/loved one's speech/language/communication**?** (Include information about when you first noticed the issues, known causes, and any specific issues such as articulation or stuttering).

____

____

____

____

____

____

Has anyone else (teacher, pediatrician, family members, friends) expressed concerns? ______YES ______NO

If yes, what were their concerns/comments? ______________________________________

____

SPEECH/LANGUAGE:

Primary Language spoken at home:____

Is your child/loved one intelligible to an unfamiliar listener? ______YES ______NO

Does your child/loved one:

Answer when you talk to him/her? ______YES ______NO

Initiate a conversation? ______YES ______NO

Talk to him/herself? ______YES ______NO

Ask for help? ______YES ______NO

Use Sign Language: ______YES ______NO

Use an Augmentative Communication Device? ______YES ______NO If yes, which one: __________

____

How does your child/loved one let you know his/her needs? ___________________________

____

EATING SKILLS:

Did your child/loved one ever have difficulty chewing, swallowing, or drinking? ______YES ______NO

Does he/she now? ______YES ______NO *(If yes, please describe)*______________________________

____

How would you describe your child/loved one's eating habits? ________________________

Have you noticed your child/loved one liking or disliking any certain food textures? ______YES ______NO

*(If yes, please describe)*____

Does your child/loved one have any food allergies? _________________________________

(Enrollment Form Continued)

PLAY SKILLS:

Does your child/loved one enjoy playing with others or by himself/herself? ______________________________

What types of toys does your child/loved one enjoy playing with most? ________________________________

____

SCHOOL: ____ GRADE: ____________________________

Is your child/loved one/loved one receiving any other therapy? _____YES _____NO

If you answered yes, please check all that apply.

- PHYSICAL THERAPY _____HOME _____CLINIC _____SCHOOL
- OCCUPATIONAL THERAPY _____HOME _____CLINIC _____SCHOOL
- FEEDING THERAPY _____HOME _____CLINIC

Any additional information that would be helpful? ____

____

____

____

SIGNATURE:

Print name of person filling out this form____

Signature of person filling out this form: _X_______________________________________

Milestone PEDIATRICS

INSURANCE INFORMATION

Patient Information

Patient Name: ____ Date of Birth: ______/______/______
Address: ___________________________ City: ______________________ State: _____ Zip: ________
Phone: (   ) ______-________ Referring Physician: ____________________________________
Phone No. (   ) _______-__________ Diagnosis: ______________________

State Coverage (AHCCCS Plans) ***Please attach a copy of the front and back of the card***

Policy Holder's Name: ________________________________ Phone No. (   ) _______-___________
Insurance Company Name: ____
Policy/I.D. #: ____________________ Group #__________________ Group Name: ___________________
Phone number on card:____
Address on card:____
Is this the only insurance coverage the patient has? ____YES ____NO (*please complete below*)

Primary Insurance ***Please attach a copy of the front and back of the card***

Policy Holder's Name: ________________________________ Phone No. (   ) _______-___________
Relation to Patient: Self ______ Spouse ______ Parent ______ Other ______ Date of Birth: _____/_____/_____
Employer: _______________________________ Insurance Company Name: ___________________________
Policy/I.D. #: ____________________ Group #__________________ Group Name: ___________________
Phone number on card:____
Address on card:____

Secondary Insurance ***Please attach a copy of the front and back of the card***

Policy Holder's Name: ________________________________ Phone No. (   ) _______-___________
Relation to Patient: Self ______ Spouse ______ Parent ______ Other ______ Date of Birth: _____/_____/_____
Employer: _______________________________ Insurance Company Name: ___________________________
Policy/I.D. #: ____________________ Group #__________________ Group Name: ___________________
Phone number on card:_________________________ Address on card:_______________________________

CONSENT TO BILL AND TREAT

I, ____, acting on behalf of ______________________________ (hereinafter referred to as "the Patient") consent to the necessary care and/or treatment of the patient by the Therapists/therapy assistants doing business for Milestone Pediatrics, L.L.C. I consent to care and treatment that falls within the scope of speech/language therapy practice as defined by the American Speech-Language-Hearing Association for Speech Therapy, or within the scope of occupational therapy practice as defined by the American Occupational Therapy Association for Occupational Therapy. I acknowledge that no guarantee has been made to me as to the result of evaluation and/or treatment.

BY SIGNING (BELOW) THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND CONSENT TO BILL AND TREAT AND ITS CONTENTS.BY SIGNING THIS FORM, I AM ALLOWING MILESTONE PEDIATRICS, LLC TO USE AND DISCLOSE MY PHI FOR TPO. I GIVE MY PERMISSION TO MILETONE PEDIATRICS TO BILL THE INSURANCE OR TO PROVIDE ANY INFORMATION REQUESTED TO THE INSURANCE COMPANY(IES) LISTED.

Signature: ____ Date: ______/______/______

*Must be signed by a parent or guardian if patient is under the age of 18.

RELEASE OF CONFIDENTIAL INFORMATION

This form serves as a formal consent to release speech/language therapy reports, medical records, psychological reports, educational records, audiological reports, and/or other pertinent information to/from Milestone Pediatrics in order to fully assess you/our family member's needs.

______________________________	________________	________________________________
Client Name	DOB	Mailing Address
______________________________		________________________________
Telephone Number		City, State, Zip

List all agencies which have served you/your family member. Please include contact name and facility name. If you have the telephone number and/or address, please supply that information.

______________________________	________________	________________________________
DES/DDD/Support Coordinator	Phone	Address
		________________________________
		City, State, Zip
______________________________	________________	________________________________
Physician	Phone	Address
		________________________________
		City, State, Zip
______________________________	________________	________________________________
School	Phone	Address
		________________________________
		City, State, Zip
______________________________	________________	________________________________
Insurance	Phone	Address
		________________________________
		City, State, Zip
______________________________	________________	________________________________
Other	Phone	Address
		________________________________
		City, State, Zip

I hereby give my consent to: Milestone Pediatrics, 600 W. Ray Rd., Ste D-1, Chandler, Az. 85225, (480) 855-0474 to obtain and exchange confidential information from the above named agencies and other agencies regarding myself/family member.

____	______________________
Signature of Patient or Parent/Guardian	**Date**
____	______________________
Print Patient or Parent/Guardian	**Relationship to Patient**

Milestone PEDIATRICS

PATIENT HIPPA AWARENESS AGREEMENT

With my permission, Milestone Pediatrics, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Milestone Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

A copy of the **Notice of Privacy Practices** was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the offices of Milestone Pediatrics, LLC may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care. With my permission, the offices of Milestone Pediatrics, LLC may mail to my home, or other designated location, any items that assist The Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that The Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, though if it does so, is bound by this agreement.

CLIENT RIGHTS

Client policies as a client cared for by Milestone Pediatrics, you have the right including, but not limited to the following:

1) To have access to services regardless of race, color, religion, sex, age gender preference, national origin, handicap or decision regarding advanced directives.
2) To be fully informed at the time of admission of these rights and responsibilities. Information shall be communicated to you in language you can reasonably understand.
3) To be informed of financial benefit, if any, to the referring organization when he/she is referred to another organization, service or individual.
4) To refuse treatment and to be informed of the possible consequences of such refusal.
5) To be assisted, along with your family, to carry your Therapist's recommendations so that you/your family can understand and assist in the care provided.
6) To be assured of confidentiality regarding your care. We may submit information to third party, such as DDD and your insurance only with your approval.
7) To be treated with consideration, respect and full recognition of dignity and individuality.
8) To have your communication needs met.
9) To be assured the personnel to provide care are qualified through education and/or experienced provide the services for which they are responsible, and to be sure that these personnel work under qualified supervision.
10) To voice grievances with respect to care that is (or fails to be) provided, to be involved in the resolving of ethical issues, or to recommend change to the agency, the patient/family.

I have received a copy of the Privacy Policy. I understand my Client Rights.

______________________________________ ______________________

Signature of Patient or Parent/Guardian ***Date***

______________________________________ ______________________

Print Patient Name ***Relationship to Patient***

ACKNOWLEDGEMENT FORM

Please read and INITIAL the following statements:

______I agree to be present or have a caregiver over the age of 18 present during therapy sessions to provide input and receive training. I will not leave the premises during therapy.

______I agree to be responsible for the safety of the client and feeding or hygiene needs that may occur during that time period.

______I hereby authorize Milestone Pediatrics, LLC to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless, otherwise noted, benefit payment will be assigned directly to Milestone Pediatrics.

______If therapy takes place in the community setting, I agree to transport the client to meet the Therapist at the predetermined time and destination and agree to bring any needed equipment such as communication devices, walker etc. necessary to work on goals and objectives.

______I agree that Milestone Pediatrics and it's Therapists are not responsible over the safety of the client in the community and the safety of others while in contact with this client. Furthermore, I agree that Milestone Pediatrics and Therapists are not responsible for damage to private and public property caused by the client while participating in therapy.

______I agreed to notify my Therapist as soon as possible if I will be unable to make a scheduled appointment. I understand that two no-shows in the four-week time period may result in the termination of services.

______I agreed to notify my Therapist if I am going to be late. If I am late more than two or more times per quarter, the regularly scheduled timeslot will no longer be reserved.

______I agree to participate in decisions regarding the frequency and duration of therapy services, including increasing or decreasing frequency of services or plan to discharge the client from services.

______I agree to allow the Therapist use food in treatment and attest that my child has no food allergies except for the following: ____

______I agree to notify Milestone Pediatrics immediately of any insurance changes, and understand that the client responsible for any charges incurred prior to notification.

______I agree that all intake paperwork and insurance forms must be submitted prior to starting services.

______I have read the Cancellation Policy and agreed to abide by this policy.

______I acknowledge the receipt of the Privacy Practices form (located on reverse side of Welcome Letter)

______I grant Milestone Pediatrics permission to use my child's photo(s) for promotional materials and publications including, but not limited to: newsletters, brochures, flyers, slideshows, posters, or web content, and is to be used for business purposes only. This permission is indefinite, or until I advise Milestone Pediatrics in writing that I no longer give my permission.

OR _______I DO NOT give my permission for my child's photo taken or used in any way.

______________________________________	______________________
Signature of Patient or Parent/Guardian	**Date**
______________________________________	______________________
Print Patient Name	**Relationship to Patient**

MILESTONE PEDIATRICS CANCELLATION POLICY

Client Name:____

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A parent/caregiver over the age of 18 must be present to PARTICIPATE during all therapy sessions. You cannot leave the premises while your child/loved one is in therapy.

____ ________________

Parent/Guardian Signature Date