



Summary of Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2025 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice Available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment, and health care operations. For example:

Treatment: We may use and disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, and credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those describes in this Notice.



To your family and friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family, member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses and disclosures. In the event of your incapability or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information what we are required to do so by law.

Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may not disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail message, text messages, postcards, or letters).

PATIENT RIGHTS

Access: you have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other cost incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years, but not before January 1, 2025. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee responding to these additional requests.



Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your requests must specify the alternative means or location, and provide satisfactory explanation will be handled under the alternative means location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complains to us and to Secretary of the Department of Health and Human Services if you believe that your privacy right have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

Right to Obtain a Paper Copy of this Privacy Summary Notice as well as the Full Privacy Notice.

Questions and Complaints

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and / or with the U.S. Department of Health and Human Services.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)



Patient Information

General Information

Child's Name: _____ Date: _____

Birth date: _____ Age: _____ Sex: _____ Male _____ Female

Primary Physician _____ Phone: _____

Referring Doctor (if different): _____ Phone: _____

Diagnosis (if known): _____

Home Address: _____

Home Phone: _____ Email Address: _____

Do you feel comfortable receiving emails regarding therapy services and your child? _____ yes _____ no

School/Preschool: _____ Grade _____

Referred By: _____

Person filling out this form: _____ Mother _____ Father _____ Stepmother _____ Stepfather Other: _____

Mother's Name: _____ Day Phone: _____

Evening Phone: _____

Father's Name: _____ Day Phone: _____

Evening Phone: _____

Marital Status of Parents: _____ Person with whom child resides: _____

Please list all people living in household:

Name Relationship to Child Age Speech/Hearing or medical problem



Primary Language spoken in the home: _____

PLEASE EXPLAIN THE CONCERNS YOU HAVE ABOUT YOUR CHILD?

(Include when this was first noticed and/or what may have caused it, etc): _____

Has anyone else expressed concerns (i.e. family members, pediatrician, teachers, etc.)?

Has your child been enrolled in any type of therapy or other treatment programs and/or received testing?

___Yes ___No

If yes, please describe the program(s): _____

Medical History:

Primary Care Physician: _____

Phone Number: _____

Developmental Physician: _____

Phone Number: _____

Pregnancy/Birth History:

List any problems or unusual stresses during pregnancy: _____



List any problems after birth (i.e.-jaundice, required oxygen, etc): _____

Birth Weight: _____ Early or Late?: _____

Did child go home with family as expected? _____ Yes _____ No

List any unusual problems during first few weeks of life: _____

Health:

Has your child has his/her hearing checked? _____ Yes _____ No Date: _____

Results: _____

Has your child has his/her vision checked? _____ Yes _____ No Date: _____

Results: _____

History of ear problems? _____ Yes _____ No

History of allergies, tonsillitis, or asthma? _____ Yes _____ No

Are there any diagnosed medical, physical, or emotional problems? _____ Yes _____ No

Have there been any serious illnesses, injuries or hospitalizations? _____ Yes _____ No

If yes to any of the above questions, please explain and give dates: _____

Developmental Milestones:

<i>Behavior</i>	<i>Age</i>
Sat up independently	_____
Crawled	_____
Walked alone	_____
Spoke first word	_____
Put several words together	_____
Dressed self	_____
Finger fed self	_____
Ate with utensils	_____
Became toilet trained	_____
Communication:	_____



Daily Behavior:

Does your child have any of the following:

Socializing problems Yes No

Feeding problem Yes No

Sleeping problems Yes No

If you checked yes for any of the above, please explain: _____

How does your child get along with other children? _____

Age of playmates? _____

How does your child usually let you know, his / her needs? _____

Does your child communicate well with you / others? _____

Does your child:

Answer when you talk to him/her? Yes No

Talk about what he/she/ is doing? Yes No

Ask for help? Yes No

What are your child's interests? _____

Please list your goals for therapy: _____



Printed Name of Parent/Guardian/Caregiver: _____

Signature of Parent/Guardian/Caregiver: _____

Date: _____



Authorization for the Release of Medical Records

I, _____ as a personal representative of _____ (name of minor patient), hereby authorize Shine Pediatrics, LLC d/b/a Shine Pediatric Therapy to obtain and release all of this patient's medical records, case records, case histories, and/or personal and regular files, for the purpose of financial reimbursement, continuity of care and case management from and to all current and former providers of medical services (to include: Primary care physicians, Psychologists, etc.) I understand and agree that a photocopy or facsimile of this executed authorization, is as valid as the original.

Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization, and my consent has been made voluntarily.

Printed name of Parent/Caregiver/Guardian: _____

Signature of Parent/Caregiver/Guardian: _____

Date: _____

Acknowledgement of Receipt of Privacy Policy

I, _____ hereby acknowledge that I have read/ received/downloaded a copy the Notice of Privacy Policy Practices with an effective date of 1-01-25, as it relates to my child _____.

Name of Child _____

Name of Parent/Caregiver/Guardian _____

Address of Child _____

Signature of Parent/Caregiver/Guardian _____

Date _____

Cancellation Policy: I fully understand my child's therapy schedule and agree to bring my child to his/her appointments as scheduled. In the event that my child will not be able to attend his/her scheduled appointment, I agree to notify his/her therapist via phone or email. I understand that my therapist reserves the right to dismiss my child from therapy if I do not adhere to this cancellation policy. I understand that my therapist reserves the right to bill a \$25 cancellation fee for any excessive or unexcused absences.



Consent to Bill and Consent to Treat

I, _____ (parent/caregiver), knowing that _____ (child) has a diagnosis requiring Occupational, Speech and/or Physical Therapy treatment voluntarily consent to such care for the aforementioned child by the therapists of Shine Pediatrics, LLC d/b/a Shine Pediatric Therapy as may be beneficial in the professional judgment of the child's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of therapy with my child.

Parent Initials _____

I hereby authorize Shine Pediatrics, LLC d/b/a Shine Pediatric Therapy to bill for reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to Shine Pediatrics, LLC d/b/a Shine Pediatric Therapy. I understand that patient or patient's family is responsible to pay all fees accrued. I agree to pay all fees within 30 days after bill has been mailed, and understand that any fees not paid within 30 days will result in a late fee. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal and/or collection fees. I understand that I am ultimately responsible for payment of all services received.

Parent Initials _____

I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping, etc assist with a variety of skills and performance components the therapist may need to address. I consent to the use of gross motor play and exempt my child and therapist(s) from any injury resulting from this type of play.

Parent Initials _____

Parent/Caregiver Signature: _____

Parent/Caregiver Printed Name: _____

Date: _____