Max★Ability
THERAPY SERVICES

Omaha
10909 Mill Valley Rd Ste 210
Omaha, NE 68154

Bellevue
1001 Fort Crook Rd N Ste 202
Bellevue, NE 68005

Phone: (402) 391-5002 Fax: (402) 343-1278
Email: therapy@maxability.org Website: maxability.org

Patient Name: _____
Date of Birth: _____

Consent to evaluate and provided treatment

☐ I hereby authorize, MaxAbility Therapy Services, P.C. to evaluate and treat:
_____ (Patient Name)

Statement of Authorization
I understand that, except for research related treatment, MaxAbility Therapy Services, P.C. will not condition my treatment upon my signing this authorization

_____ _____
Patient or Legal Guardian Printed Name Date

_____
Patient or Legal Guardian Signature

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Patient Name: _____

Financial Policy

Date of Birth: _____

Welcome to our office! We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance, and your understanding of our financial policy.

Please read carefully & initial:

1. _____ Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. Benefits are verified. You are financially responsible to MaxAbility Therapy Services as the parent, guardian, or insured for all charges not paid by your insurance.
2. _____ Our fees are generally considered to fall within the usual, customary, and reasonable (UCR) range by most insurance carriers. Occasionally an insurance company reimburses based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area. MaxAbility does not accept arbitrary fee determinations for services a carrier considers not medically necessary. We cannot accept responsibility for negotiating settlements on disputed claims. Not all services are in all contracts.
3. _____ MaxAbility enters an agreement with insurance carrier's contingent that claims will be processed and paid in a timely manner. If an insurance carrier has not processed and paid a claim within 120 days of submissions you, the subscriber, agree to pay the pending balance or services will be held until balance is paid in full or payment arrangement has been established.
4. _____ If your plan has visit limits and those benefits are exhausted, client agrees to make full payment at the time of service. It is the subscriber's responsibility to monitor benefits such as deductible and visit limits. It is your responsibility to determine if a referral or prior authorization are required for any procedures performed.
5. _____ MaxAbility partners with PatientPay a payment system that provides electric bills via text, e-mail and paper statement through mail; these communications will have links to view bills, make payments and payment arrangements. Payment arrangements are made based on balanced due. If your balance reaches $1,000 your services will be held until balance is paid in full and/or payment arrangement has been established. If you're unable to pay your balance promptly, you will be contacted by our collection vendor.
6. _____ MaxAbility will submit claims on your behalf for reimbursement to the insurance company you provide to us; however, it is your responsibility to keep MaxAbility informed of any changes to your insurance coverage. If your insurance changes and you do not notify MaxAbility prior to the start of your therapy session, the session balance will be transferred to patient responsibility.
7. _____ A no-show fee of $25 will be charged for any missed appointment(s) without 24 hour notice to the start of your therapy session. This fee is due prior to your next scheduled visit. If the no-show fee is not paid before the start of your next session, the session will be canceled.
8. _____ We collect ALL outstanding balances prior to each visit, if you have no insurance coverage (self-pay), payment in full is due at the time of service.
9. _____ Any returned check will be subject to a NSF fee of $35.00, due at the next visit.

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Financial Policy – Page 2

Date of Birth: _____

Plan of Care / Payment Plan:

- Recommended frequency & duration of therapy_____
- Insurance Deductible_____ Co-Insurance_____
- Co-Pay_____ Visit Limit _____
- Amount payable at each visit_____

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

I hereby understand the above financial policy and agree to abide by it.

_____ _____

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Scheduling and Attendance/Cancellation Policies

Welcome to MaxAbility! We strive to provide you with the best therapy outcomes possible. For the best opportunity to achieve this, 100% attendance at the frequency established in your or your child's plan of care is optimal, but we do understand occasional changes are necessary due to illness, vacations, etc. Please review and initial the following policy statements regarding attendance and cancellations.

_____ Following an evaluation the client will be scheduled based on the frequency recommendation from the therapist(s). This will be your therapy time slot moving forward. This time is reserved for the client for the duration of their plan of care as long as all other policies are being followed (including attendance/cancellation and financial).

_____ Attendance of 75% is required to maintain your weekly therapy time slot. If you fall below 75% and you are unable to correct this issue, the client will be removed from the schedule.

_____ If you need to cancel your appointment for any reason, please call or text the office within 24 hours of the scheduled appointment in order for your session to be considered "excused."

_____ Arriving late to your appointment will result in a shortened session. 2 or more late arrivals may warrant a change in your scheduled therapy appointment time.

_____ If an appointment is not cancelled and the patient does not show up, it will be considered a "no show" visit. Two consecutive "no shows" will result in being removed from the schedule.

_____ Please make all cancellations or schedule changes through the front office. Schedule changes made only with the therapists will not be accepted.

_____ Pediatric only: We want you to be an active member of your child's therapy team. If you are bringing a child to their therapy appointment and choose not to stay with them, you are required to remain on the premises.

_____ If you are unable to maintain the determined frequency and cannot schedule at the same time each week, you will need to call the office week by week to schedule; however, we cannot schedule these out more than 1 week in advance.

_____ A no-show fee of $25 will be charged for any missed appointment(s) and without 24 hour notice to the start of your therapy session. This fee is due prior to your next scheduled visit. If the no-show fee is not paid before the start of your next session, the session will be canceled.

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Release of Information

☐ I hereby authorize, MaxAbility Therapy Services, P.C. to request information FROM and release TO: _____
(Individual or Organization Name)

Records to be Released could include any of the following:

Date(s) treatment was received: _____

☐ Consultation Report ☐ Entire Report ☐ History & Physical ☐ Evaluation
☐ Plan of Care ☐ Photographs, Videos, & Digital Images ☐ Other

☐ Script for Speech Therapy Evaluation and Treatment
☐ Script for Occupational Therapy Evaluation and Treatment
☐ Script for Physical Therapy Evaluation and Treatment

Purpose of Release could include any of the Following
☐ Coordination of Care ☐ Insurance ☐ Litigation ☐ Personal ☐ Other
☐ Training of Medical professionals/students

Statement of Authorization

- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to MaxAbility Therapy Services, P.C. A photocopy of this authorization will be treated in the same manner as the original
- I understand that once information is released as specified in this authorization, the facility, their employees and MaxAbility Therapy Services, P.C., cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information

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WAIVER AND RELEASE FROM LIABILITY

I understand there are risks. I consent to participate in clinic activities and events. I understand that I am responsible for my actions and participation. I agree to be bound by the terms of this document.

I understand the legal consequence of signing this document and I agree to be bound by the terms of this document, (a) releasing MaxAbility Therapy Services P.C. from all liability, (b) waiving my right to sue MaxAbility Therapy Services P.C. or it's employees, (c) and assume all risks of my participation in services, actives and events organized by MaxAbility Therapy Services P.C.

I have read this document, I am signing it freely.

_____ _____
Patient or Legal Guardian Printed Name Date

_____
Patient or Legal Guardian Signature

CONSENT WAIVER and RELEASE - Promotional Material

I, the undersigned, hereby give consent to MaxAbility Therapy Services, P.C. to use for demonstration and/or promotional purposes any material compiled before, during, or after my examination and therapy. This includes photographs, tapes, or audiovisual illustrations which may help to inform the public and/or promote the cause of specified therapies or devices. This also includes commentary by the patient or family which may be quoted to promote the Company, its therapies or devices. I understand the subject material may appear in written publications (such as brochures), on radio or television, or on the Company's website or social media (facebook, insta, tiktok, ect)

I further understand that MaxAbility Therapy Services, P.C. is a private corporation established to develop and market assistive living devices for persons with disabilities. In addition to the material covered above, I volunteer to be contacted by interested parties to share the success of my treatment.

I hereby waive my rights to privacy in connection with the consent given above, and I hereby release, discharge, and agree to hold harmless from any liability now or in the future to MaxAbility Therapy Services, P.C.

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Privacy Policy

PRIVACY POLICY

As required by privacy regulations created as a result of the Health Insurance Portability/Accountability Act of 1986, **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.

Commitment to Privacy:

This clinic is committed to maintaining the privacy of your protected health information(PHI). We are required by law to maintain the confidentiality of your health information. We also are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in this clinic concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect.

We may use and Disclose Your Protected Health Information (PHI) in the Following Ways:

1. Treatment: This clinic may use your PHI for treatment purposes. We may disclose your PHI to other health care providers for purposes related to your treatment. This may include, but is not limited to, your doctor, other therapists, caseworker, and school related personnel.
2. Payment: This clinic may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs.
3. Health Care Operations: This clinic may use and disclose you PHI to operate our business. An example of this is, using your PHI to evaluate the quality of care you receive from us.
4. Appointment: This clinic may use and disclose your PHI to contact you and remind you of an appointment. An example of this is leaving a message on your answering machine.
5. Release of Information to Family/Friends: This clinic may release your PHI to a friend or family member that in involved in your care. For example, if a friend, babysitter, grandparent, or other family member brings you or your child to the clinic for care, they will receive medical information abour your or that child.
6. Disclosures Required by Law: This clinic will use and disclose your PHI when we are required to do so by federal, state and/or local law.

Uses and Disclosure of your PHI in Certain Special Circumstances:

1. Public Health Risks: This clinic may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of reporting child abuse or neglect, maintaining vital records, preventing or controlling disease, injury or disability, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting problems with products or devices, notifying individuals that a product or

device they may be using has been recalled, or notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities: This clinic may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor governmental programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings: This clinic may use and disclose your PHI in response to a court order, if you are involved in a law suit or similar proceedings.
4. Law Enforcement: This clinic may release PHI if asked to do so by a law enforcement official regarding a crime victim. If we are unable to obtain the person's agreement, concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, or in an emergency, to report a crime.
5. Serious Threats to Health and Safety: This clinic may use and disclose your PHI when necessary to reduce or prevent a serious threat to you or your child's health and safety of the health and safety of another individual.
6. Military: This clinic may disclose your PHI in you are a member of US or foreign military forces and if required by the appropriate authorities.
7. National Security: This clinic may disclose you PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. Inmates: This clinic may disclose your PHI to correctional institutions or law enforcement officials in you or your child is an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care service to you or your child, for the safety and security of the institution and to protect your health and safety or the health and safety of other individuals.
1. Workers' Compensation: The clinic may release your PHI for workers' compensation and similar programs.

Your Rights Regarding Your PHI:

You have the following rights regarding your PHI that we maintain about you or your child. Request involving your rights must be submitted in writing.

1. Confidential Communications: You have the right to request that our clinic communicate with you about health related issues in a particular manner or at a certain location. The request must specify the method of contact or the location where you wish to be contacted. We will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure or your PHI to only certain individuals involved in your care or the payment for your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must describe in a clear and concise fashion the information you wish restricted, whether you are requesting to limit our clinic's use, disclosure or both and to whom you want the limits to apply.
3. Inspection and Copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you or your child, including patient medical records and billing records. This clinic may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.
4. Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by or for this clinic. You must provide us with a reason that supports your request for the amendment. Also, we may deny your request if you ask us to

amend information that is in our opinion accurate and complete, not part of the PHI, not created by our clinic or that individual/entity that created the information is not available to amend the information.

5. Accounting of Disclosure: All of our patients have the right to request an "accounting of disclosures" which is a list of certain non-routine disclosures our clinic has made of your PHI for non-treatments, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our clinic is not required to be documented. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 15, 2003.
6. Right to a Paper Copy of this Notice: You are entitled to receive a paper copy of this notice of privacy practices at any time. A written request is not required.
7. Right to File a Complaint: If you believe your privacy rights has been violated, you may file a complaint with this clinic's privacy officer, the Office of Civil Rights, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
8. Right to Provide an Authorization for Other Uses and Disclosures: This clinic will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you or your child's PHI may be revoked at any time in writing. After you revoke your authorization, we will not longer use or disclose your PHI for the reason described in the authorization. Please note we are required to retain records of your care.
9. If you have any questions or correspondence : Please contact Melody Charelson, Privacy Officer for MaxAbility Therapy Services, P.C.

Effective March 29, 2011

*This form is educational only, does not constitute legal advice, and covers only federal, not state law (August 13, 2002).

I have received a copy of the Privacy Policy and Universal Precautions Policy

_____ _____

Patient or Legal Guardian Printed Name Date

_____

Patient or Legal Guardian Signature

Max★Ability
THERAPY SERVICES

Therapy Parent Questionnaire

Child's Name: _____ Birth date:_____
Child lives with (Check one): □ Mom □ Dad □ both parents □ Shared custody □ Other: _____
Mom's Name: _____ □ Birth/adoptive parent □ Step parent □ Guardian □ Other: _____
Dad's Name: _____ □ Birth/adoptive parent □ Step parent □ Guardian □ Other: _____
Primary language spoken in home: _____
Primary Physician: _____ Specialists: _____

Medical History

Birth weight: _____ [ ] Full Term Pregnancy [ ] Prematurity - Born at _____ weeks

Type of delivery: _____

Complications at birth for baby:[ ] cyanosis [ ] limpness [ ] stiffness [ ] congenital defect
[ ] feeding [ ] seizures [ ] ventilator [ ] other _____

If any above are checked, please provide additional information:

_____

_____

Please describe any important illnesses, injuries, or surgeries: (tonsils, adenoids and tubes) Please include date(s):

_____
_____
_____

Current medical diagnoses/conditions (ADHD, Autism, LD, CP etc.): _____
_____

Current medication(s) dosage and why used:_____
_____
_____

Allergies: _____

Dietary Restrictions: _____

History of ear infections or hearing loss: _____

If yes, hearing aids worn? YES NO

Do any immediate or extended family members have history of communication/speech/fluency problems?

_____

Vision Impairment: YES NO Glasses: YES NO

Bowel/Bladder Difficulty: YES NO

Does your child use any special equipment (wheelchair, AFOs, splints, walker, speech generating device etc):_____

_____

_____

Developmental Milestones

Approximate age at which your child did the following:

Milestone	Age Appropriate	Advanced	Normal	Delayed
Raised Head, lying on stomach	3-4 months			
Rolled Over	5-7 months			
Babbles long strings of sounds	7-9 months			
Sat Alone	6-9 months			
Crawled on hands and knees	7-10 months			
Pulled to stand	9-11 months			
Stood Alone	10-12 months			
Walked	12-15 months			
First word	10-15 months			
Drew with a crayon	12-18 months			
Jumped	2-2.5 years			
Cut with scissors	2-3 years			
Toilet trained	3 years			
Rode a tricycle	2.5-3 years			
Self-fed with utensils	3.5 years			
Dressed/undressed self	4 years			
Rode a bicycle	5-6 years			
Tied shoes	5-7 years			

What percentage of the child's speech do you (caregiver) easily understand? _____

What percentage of the child's speech do others/unfamiliar people easily understand? _____

Does your child do the following?

Identify pictures in books?	YES	NO	Express emotion appropriately?	YES	NO
Engage in conversations?	YES	NO	Engage in creative/pretend play?	YES	NO
Follow simple 1-step instructions?	YES	NO	Express difficulty sleeping?	YES	NO
Follow multistep instructions?	YES	NO	Make friends easily?	YES	NO
Complain of pain?	YES	NO	Answer simple questions?	YES	NO

Concerns for Your Child

Please check all areas of concern:

Fine motor		Muscle tone		Sensory Processing	
Motor weakness		Endurance		Speech/articulation	
Feeding		Attention/ Distractibility		Following Directions	
Dressing		Play skills		Language	
Toileting/Restroom routine		Over/Under active		Oral Motor	
Handwriting		Over sensitive/Under responsive		Safety (self abuse, elopement, etc)	

Please further describe your concerns: _____

_____

_____

Educational History

School/Daycare/Preschool:_____ Grade:_____ Teacher(s):_____

Does your child have an IFSP or IEP? _____

Goals and Background

Is your child currently receiving any therapy or involved in any special programs? _____

_____

What other evaluations, therapy or special programs has your child had in the past and when? _____

_____

What are your goals for your child? _____

_____

_____

_____

What are your child's strengths? _____

_____

What are your child's favorite/preferred activities and toys? _____

_____

Thank you for completing the form. We look forward to meeting you and your child.

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