Miss Shannon's Therapy 4 Kidz
2449 N Tenaya Way Unit 34991
Las Vegas, NV 89128
1(702)970-9242
Info@missshannonstherapy4kidz.com

Who We Are

"Play is often talked about as if it were a relief from serious LEARNING.
But for children play is serious learning.
Play is really the WORK of childhood.
Play gives children a chance to **practice** what they are learning." Fred Rogers

Miss Shannon's Therapy 4 Kids is an intimate therapy practice dedicated to providing a unique and individualized therapy plan for your amazing child. Our practice remains small and close-knit so we are able to invest our time in your child's intervention and not worry about an overwhelming caseload and productivity standards. We hope to bring best practice and evidenced-based pediatric interventions to facilitate the optimal potential in your child. Knowing that we cannot do this alone, we work with your child, your family, your community, and other professionals to ensure the best possible outcome for your child. We are not afraid to think "out of the box" to discover what works for your child. We are a community-based service model incorporating clinic, home, and community settings with parent, siblings, family, and community education to support your child.

"Watching a child makes it obvious that the **development** of the mind comes from **movement**.
and
Play is the WORK{occupation}of the **Child**" Maria Montessori, MD

How We Started

Shannon Holman, OTR/L, BCP hopes to bring passion and progress to the children and families she works with. She is dedicated to incorporating pediatric best practices & evidence-based interventions as well as 30 years plus of hands-on experience in multiple pediatric settings to the care of her patients. Providing care through a community based service model allows her to provide intervention that best helps the child and family. She has experience in CP, Autism, Asperger's, ADHD, SPD, and much more, in children birth to 23 years of age.
Shannon graduated with a Bachelor of Arts from the College of St. Catherine in 1990 with a major in Occupational Therapy. She is a NBCOT Occupational Therapist Registered (OTR) and licensed in the State of Nevada. She earned her IBCCES Certified Autism Specialist and her AOTA Autism Badge in 2022, Astronaut Training by Vital Links in 2019, AOTA Fieldwork Educator in 2017, Board Certification in Pediatrics (BCP) in 2016, SIPT Certification in 2004, and NDTA NDT Certification in1994. She is a proud member of AOTA. She holds certifications & training in sensory integration, sensory processing, NDT, MFR, CST, Autism, ADHD, RAD, handwriting, behavior, and play. She is eager and passionate in guiding OT interns on their pediatric journey and you will often find multiple students with her.
Shannon embraces sensory processing & is passionate about educating others regarding its role in our daily health & happiness. She is committed to ongoing continuing education in pediatrics and attends courses yearly. She is most fortunate to be able to collaborate with incredibly knowledgeable and gifted occupational, physical, and speech therapists and believes this assists her in being able to treat the "whole child".
Shannon has lived in Las Vegas since 1980 and married a Las Vegas native. She now has 2 natives that remain in Las Vegas and when not working, she looks forward to spending time with family, friends, and her crazy cats. She can often be found reading, crafting, or at Disneyland with her family.
One of Shannon's OT interns shared this quote from basketball legend Magic Johnson and Shannon believes it sums up her purpose and role in the journey with her patients and families,

"All **kids** need is a little HELP, a little hope and somebody who believes in them."

Our Village

Miss Shannon's Therapy 4 Kidz is built upon the energy, enthusiasm, and dedication of many talented therapists that have chosen to specialize in pediatric therapy. We are board certified state licensed therapists with multiple years of continuing education in pediatric therapy, some therapists are even board certified in pediatrics. With over 30 years of combined experience we strive to provide the best skilled pediatric therapy with emphasis on habilitation and rehabilitation for children birth to 23 years of age. Our amazing team has served children in the Las Vegas area in various settings and models for over 3 decades and hope that our past experiences help us help you find your child's optimal level of fun and function. All of our staff bring dedication, compassion, and skill to work as a team in order to collaborate with you, your child, and your team. It is only is collaboration with therapist, child, and family that we are able to achieve results.

Our Scope of Practice

Miss Shannon's Therapy 4 Kidz provides pediatric services to children ages birth to 18 years. Over 18 years of age will be considered on a case by case basis. We have experiencing in working with, but not limited to: Autism Spectrum Disorder, ADHD/ADD, Apraxia, Behavior Challenges, Cerebral Palsy, Childhood Trauma, Down Syndrome, Developmental Delays, Developmental Coordination Disorder, Executive Function Challenges; FAS, Genetic Syndromes, Gross and Fine Motor Delays, Handwriting, Head Injuries, Disabilities, Neurological Disorders, Play Skill Delays, Prematurity, Self-Care Skill Delays, Sensory Processing Disorder, Sensory Integration Challenges, Social and Emotional Disorders, and Visual Perceptual and Visual Motor Integration Challenges. We are always open to new challenges and are willing to learn about new and rare diagnosis. Although a diagnosis assists us with referrals and reimbursement, we focus our intervention on what your child needs, what are their strengths and challenges, and what are your child and family goals.

Who and How: Children who experience challenges in any area of development (motor skills, social/emotional skills, play skills, behavior, sensory processing skills, etc) which is inhibiting their ability to meet their optimal level of independence; participate in family, community, and school; and/or experience quality of life with their best version of self.

1. We complete an evaluation, by a licensed and credentialed therapist, based on your child's strengths and challenges and your and/or your child's goals to assist in determining the need for intervention. We also take into consideration the areas of expertise of therapy staff, the availability of appropriate treatment materials and equipment, the appropriate environment for your child, and the safety of your child and our staff. If we believe your child would benefit from treatment but is not appropriate for our services at Miss Shannon's Therapy 4 Kidz due to the factors stated above, we will work with you to attempt to find the appropriate referral, agency, or practice that can provide the needed services.
2. We establish a treatment plan and goals, again with a licensed credentialed therapist in collaboration with you and your child. In a collaborative process with your child, you/your family, and the therapist and/or therapist assistant, goals are established and reassessed (anywhere from every 6th visit to every 6 months often driven by insurance requirements, but no less than every 6 months) to determine frequency and duration of services.
3. Your child is scheduled for therapy sessions which may be with a licensed therapist or therapist assistant under the supervision of the licensed therapist.
4. There may be times when your child qualifies for services, however due to scheduling we are unable to provide a consistent optimal time for your child's therapy session. At this time, we will place your child on our on-list. This process will allow you to be called whenever there is an opening on the schedule to give you the opportunity to access services.
5. Discharge planning begins at the evaluation, we love your child, but it is not our goal to keep them in therapy for ever. We collaborate with you to best use all resources to facilitate optimal functional independence over the lifespan. However, there are some instances when discharge will occur: *no longer demonstrates the need for intervention*-a child has demonstrated progress and testing/reporting indicate child is functioning at their best level of independence, the therapist will collaborate with the family, address concerns, establish appropriate community referrals if appropriate, and establish a discharge date with a celebration of success; *does not appear to benefit from continued services*-progress in therapy is reviewed on an ongoing basis, if after 6 months, progress is not demonstrated, further collaboration with family and treatment team will occur which may result in revision of treatment plan to better fit the child's needs. If, following the second 6 month period, progress and/or goal attainment has not been demonstrated, another collaboration will occur with discussion to include possibility of treatment plan revision, increasing/decreasing frequency of sessions, and discharge. If at the end of the third 6 month period, there has been no progress and/or goal attainment, and the previously steps were followed, the child may be discharged; *the child and/or family are unwilling over a period of time to work towards agreed upon goals*-if the family and/or child refuse to participate in therapy sessions in an appropriate and therapeutic manner as well as do not comply with home activities*; safety of child, peers, and/or staff*-other people accessing services at Miss Shannon's Therapy 4 Kidz, including family members, peers, staff or the person themselves are at risk of harm; *are not meeting financial responsibilities to Miss Shannon's Therapy 4 Kidz*-if a family is unable to meet their financial obligations to Miss Shannon's Therapy 4 Kidz and have not made any payment arrangements as outlined in the Financial Policy; *do not meet the required attendance*-poor attendance as outlined in the Attendance Policy; *demonstrate severe incompatibility with others and/or therapists at Miss Shannon's Therapy 4 Kidz*-if a family and/or child is unable to interact/behave in an appropriate and respectful manner to peers, therapists, staff, and environment; *child demonstrates dramatic health changes*-child's health requires a significantly increased level of care or a service model that is not available/provided by Miss Shannon's Therapy 4 Kidz; *are removed at the request of the caregiver*-discharge will be completed upon caregiver request; or

are removed at the discretion of the Miss Shannon's Therapy 4 Kidz –Miss Shannon's Therapy 4 Kidz reserves the right to discharge/refuse service to any client at any time. Any persons whose services are terminated has the right to appeal.

6. Miss Shannon's Therapy 4 Kidz dedicated to establishing an intentional relationship with you and your child based on honesty, trust, and transparency. We believe continuity of care is vital to facilitating tolerance to challenge and progression of skill. However, due to the nature of therapy, there may be times when your child will experience a change in therapists. We will work hard to give as much notice as possible to prepare for these changes: therapist relocation; lack of "the right fit" of child and therapist resulting in lack of progress/plateau of progress or not developing a therapeutic relationship; caregiver request; family request for time and day change of ongoing therapy sessions; and change in therapist's availability. Unfortunately, there may be times when this is not possible: therapist out sick/family emergency; family and/or therapist request schedule change for with short notice; and unexpected issue (scheduling, transportation, technology, etc). Miss Shannon's Therapy 4 Kidz will work with you to accommodate changes in a timely and proactive manner to facilitate a positive and smooth transition for all.
7. Termination of Services: Every client has the right to terminate their services with Miss Shannon's Therapy 4 Kidz at any time and without prejudice for future access to services. We ask that you participate in an exit interview to discuss the reason for departure and obtain feedback about how we can improve. Miss Shannon's Therapy 4 Kidz will provide assistance at your request to support exiting or changing services. If we are not the right match for you and your child, we want to assist in transitioning your child as quickly and smoothly as possible to their next therapist.

What

Your child's intervention is based on and developed around clinical reasoning, theories of practice, and evidence-based practice. These include, but are not limited to: **Adaptive Equipment**; **Aquatic Therapy**; **Astronaut Training**-a sound activated vestibular-visual protocol for moving-"as a bridge between sensory processing and movement control, the vestibular system play a major role in everything we do…"-M. Kawar, MS, OTR and S. Frick, OTR; **Education** of child, family, and caregivers-"it takes a village"; **Executive Function Activities**; **Fine and Gross Motor Activities**; **Functional Communication**-is not the same as speech and language development; **Myofascial Release**-the gentle release and facilitation of your myofascial tissue to allow for movement; **Neuro-Developmental Treatment** (NDT)-enhance motor function ability to facilitate functional independence; **Play**-play is the occupation of children; **Self-Care Activities**; **Sensorimotor Activities**-the foundation of which to build all other skills result in the integration of reflexes and establishment of core muscles, "…critical developmental scaffolding which supports higher cognitive function."-C. Kaoscinski, MOT, OTR/L Sensorimotor Interventions; **Sensory Integration/Sensory Processing**; **Social-Emotional Activities**; and **Visual Perceptual** and **Visual Motor Integration Activities**.

Please feel free to call us for more information or if you would like to talk to a therapist prior to scheduling at 702-970-9242 or email us at info@missshannonstherapy4kids.com. Please visit us at www.missshannonstherapy4kidz.com.

When

Hours of Operation: By Appointment Only

Where

Currently: Home and Community-Based Services

What Can We Do Better

We strive to provide evidenced-based interventions incorporating best practices and collaboration with family, child, team, and community. We use an outcome-based approach defined by the collaborative team.
We are committed to delivering services with care and competence to facilitate the optimal potential for your child. We expect you to provide us with feedback on our services, both compliments and complaints while we promptly address concerns and comments. Provide us with feedback regarding our therapy services and how we can improve. Be honest with us, communicate with us, if you find that you don't know your plan of care, understand the goals, are unable to follow through with home activities, or no longer want services, let us know so that we can work together to facilitate change or discharge.
For comments and/or complaints please feel free to contact us via phone or email at 702-970-9242 or misshannon@missshannonstherapy4kidz.com. Please allow us 2 business days to respond.

How We Hold Ourselves Accountable and What We Expect From You

First and foremost, Miss Shannon's Therapy 4 Kidz honors the professional codes of conduct established per each discipline.

Per the **American Occupational Therapy Association**:

1. **Professional Integrity, Responsibility, and Accountability:** Occupational therapy personnel maintain awareness and comply with AOTA policies and Official Documents, current laws and regulations that are relevant to the profession of occupational therapy, and employer policies and procedures.
2. **Therapeutic Relationships:** Occupational therapy personnel develop therapeutic relationships to promote occupational well-being in all persons, groups, organizations, and society, regardless of age, gender identity, sexual orientation, race, religion, origin, socioeconomic status, degree of ability, or any other status or attributes.
3. **Documentation, Reimbursement, and Financial Matters:** Occupational therapy personnel maintain complete, accurate, and timely records of all client encounters.
4. **Service Delivery:** Occupational therapy personnel strive to deliver quality services that are occupation based, client centered, safe, interactive, culturally sensitive, evidence based, and consistent with occupational therapy's values and philosophies.
5. **Professional Competence, Education, Supervision, and Training:** Occupational therapy personnel maintain credentials, degrees, licenses, and other certifications to demonstrate their commitment to develop and maintain competent, evidence-based practice.
6. **Communication:** Whether in written, verbal, electronic, or virtual communication, occupational therapy personnel uphold the highest standards of confidentiality, informed consent, autonomy, accuracy, timeliness, and record management.

As a practice/clinic we strive to:

- Establish an intentional relationship with family and patient.
- Honor the culture, diversity, beliefs, and values of the family and patient by treating family and patient with courtesy, dignity, and respect, without discrimination.
- Engage in active listening to build upon the strengths of the patient while meeting the needs of family and patient. Include family and patient (if appropriate) in discussions regarding treatment plan, goals, services, programs, and outside supports.
- Honor and respect each individual's ability, expression, and self-determination while guiding and providing support towards optimal level of independence for patient and family.
- Respect privacy of the family and patient while integrating community interactions/skills.
- Provide a safe environment with competent, skilled, and caring therapists to provide "the just right challenge" to facilitate growth and development.
- Employ therapists that act with integrity, honesty, and transparency.
- Advocate for our therapists to provide up-to-date knowledge, use of best practice, and evidence-based interventions for our patients by ensuring ongoing professional continuing education.
- Use of community resources and referrals and engagement with family and friends to provide support and services for the "whole child" in the ways You want.

As our patient/family, we expect you to:

- Provide us with information (positive and negative) that allows us to make informed decisions and treatment plans to best support and safety for you and your child.
- Act with respect and safety towards other families and patients accessing our services as well as all of our staff.
- Provide us with appropriate notice when things change and you must change or cancel an appointment.
- Promptly pay deductibles, copays, and fees associated with services provided.
- Follow through with plans of care including home activities.
- Expect you to provide us with feedback on our services, both compliments and complaints while we promptly address concerns and comments.
- Provide us with feedback regarding our therapy services and how we can improve.

Be honest with us, communicate with us, if you find that you don't know your plan of care, understand the goals, are unable to follow through with home activities, or no longer want services, let us know so that we can work together to facilitate change or discharge.

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Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Miss Shannon's Therapy 4 Kidz to use and disclose my protected health information to carry out the following:

- Treatment, direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment for third party payers (i.e. my insurance company).
- The day to day healthcare operations of Miss Shannon's Therapy 4 Kidz.

☐ I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, and that these requests must be submitted in writing and agreed upon by Miss Shannon's Therapy 4 Kidz.

☐ I understand that I may revoke consent, in writing, at any time. However, any use or disclosure that occurred prior to the date Miss Shannon's Therapy 4 Kidz receives written request is not affected.

☐ I understand that the complete Privacy Policy is available to me at any time and is attached at the end of the packet.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

*DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

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Consent Forms

Child's Name:_____ Parent/Guardian's Name:_____

Welcome to Miss Shannon's Therapy 4 Kids, we are pleased you have chosen us to be a part of you and your child's journey to their best version of self. Miss Shannon's Therapy 4 Kidz offers pediatric services for children birth to 23 years of age referred to our practice. We are therapists fully licensed by our respective boards and the state of Nevada, some of our therapists carrying further certifications for the specialty of pediatrics. We strive to collaborate with you and your child to create an individualized treatment plan following our initial assessment. In order to provide therapy services we ask that you complete the following forms, please mark N/A in any areas that do not apply to your child so that we know no areas of information were overlooked. Each and every healthcare insurance has different requirements for coverage and we will strive to provide all necessary information, however, if your insurance does not cover services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

General Acknowledgement and Consent for Treatment

☐ **General Consent for Treatment:** By initialing, I am aware of my child's diagnosis and wish to receive services at Miss Shannon's Therapy 4 Kidz. I authorize the employees of Miss Shannon's Therapy 4 Kidz and all other persons caring for me to treat me in ways they judge to be of best practice and beneficial to me and/or my child/minor. I understand that this may include evaluation, testing, and treatment. I understand that my treating therapist(s) will do their best to explain to me the nature of the proposed care, treatment services, and suggested interventions. I further understand that no guarantees have been made to me regarding the outcomes of these services.

☐ I authorize Miss Shannon's Therapy 4 Kidz the release of such information that may be necessary for care via written, oral, electronic, and facsimile communication among care providers/physicians, insurance companies, the staff of Miss Shannon's Therapy 4 Kidz, and all other related persons as it relates to my treatment or payment for services provided.

☐ I authorize Miss Shannon's Therapy 4 Kidz to release information regarding the treatment session to any family member or adult bringing my child to his/her appointments.

These individuals are NOT to receive information:_____

☐ I understand that Miss Shannon's Therapy 4 Kidz is a teaching institute and is dedicated to the education of therapists and that authorized (under contract with educational institution), appropriately supervised students (both direct and indirect supervision from licensed therapists) and new graduates may observe and assist in my child's evaluation, treatment, and care.

Please initial the following OPTIONAL statement:

___I hereby give permission for me and/or my child to receive services from authorized students.

___I do NOT give permission for me and/or my child to receive services from authorized students.

___ I hereby give permission for me and/or my child to be observed by authorized students.

___ I do NOT give permission for me and/or my child to be observed by authorized students.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

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Acknowledgement of Responsibility for Payment and/or Assignment of Benefits

Financial Policy and Fee Agreement

Thank you for choosing Miss Shannon's Therapy 4 Kidz. We strive to provide the best care possible for your child and your family. We will work hard to assist your child in receiving his/her maximum allowable benefits, but ask that you assist and understand our financial policy. Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We are a cash free practice, we accept checks, credit, and mobile payment services (i.e. Venmo). It is important that you understand that you are financially responsible for all charges, whether or not they are paid by insurance.

Many healthcare insurance companies have therapy service coverage limitations. We will do our best to keep you informed of such limitations. It is important that you are aware of your benefits, as once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of your child's services. Many insurance companies also have deductibles, copays, and/or coinsurances for therapy services that are the financial responsibility of the patient, again we will work hard to keep you informed, however you understand that it is your responsibility to be aware of your benefits and coverage. Miss Shannon's Therapy 4 Kidz will not discontinue your child's services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements.

Please read carefully:

1. Your healthcare insurance policy is a contract established between the insurance company, your employer, and you. It does not include Miss Shannon's Therapy 4 Kidz, however as a courtesy, we bill your insurance company for services rendered as we accept and process payments through a variety of insurance providers. Coverage, however is based on diagnosis, procedure codes, referring provider, and insurance plan. Miss Shannon's Therapy 4 Kidz strongly recommends that you contact your individual provider to fully understand their benefits, including deductibles, copays, exclusions, and allowed number of therapy visits. As a reminder, your insurance is a contract between you, your employer, and your insurance company, and as such Miss Shannon's Therapy 4 Kidz is not liable for gaps in coverage, lack of coverage, or other insurance denials or disputes. If, after 60 days from the date of service (standard timely reimbursement), your insurance has not paid for services, you agree to make arrangements for prompt payment.
2. Please inform our office of insurance coverage changes as soon as possible. Failure to provide current information will result in your account and all future balances being your responsibility. We will no longer be able to bill your insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.
3. Miss Shannon's Therapy 4 Kidz fees generally fall within the acceptable range by most insurances and thus are covered up to the maximum allowance determined by each company. This applies only to companies who pay a percentage of the usual and customary rate. This, however, does not apply to companies that use an arbitrary fee schedule as this has no relationship to the current standard and cost of care in our area.
4. Not all therapy services are a covered benefit. Some insurance companies have services they will not cover and if this is the case, these services fall to your financial responsibility. Please be aware that if your insurance company indicates your child's services were "not medically necessary", you are still financially responsible for services rendered. We will be happy to work with you, but will not take responsibility, in negotiating settlements on disputed cases.
5. Any returned checks will be subject to a NSF fee of $35.00 which will be due at the next visit.
6. Accounts that are past due will incur a charge of $30.00/month. Miss Shannon's Therapy 4 Kidz is very aware of our changing times and realize that temporary financial challenges can have an impact on timely payments, please just give us a call immediately so we can work with you.
7. Cancellations without 24 hour notice may be assessed

Please be sure that you understand the financial agreements regarding insurance reimbursement, methods of payment, and dues regarding cancelations, missed appointments, late pick up, and past due accounts. If you have any questions or concerns about your individual policy and its coverage, please speak directly with your provider prior to signing this agreement.

If you have any questions about the above information, insurance coverage, payment arrangements, or financial responsibility please feel free to contact us. We want to make sure your focus can be on your child's intervention.

*DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

By signing below, I understand and acknowledge that I am financially responsible for paying all costs for evaluations, testing, and treatment services I and/or my child receive from Miss Shannon's Therapy 4 Kidz. I understand that I may be financially responsible for such costs even if I have health insurance/Medicaid, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance/Medicaid, including deductibles, co-payments, and services not covered and/or "not medically necessary". I agree to pay Miss Shannon's Therapy 4 Kidz for services provided to myself and/or my child. The Verification of Benefits provided by Miss Shannon's Therapy 4 Kidz is only an explanation of coverage provided by my insurance company and is NOT a guarantee of coverage and/or payment. If my insurance company fails to provide the correct information or at any time changes its coverage, I am aware that I will be responsible for payment of services.

___I agree that myself and/or my child is covered by the insurer(s) that I have shared with Miss Shannon's Therapy 4 Kidz, and that I have received no notice of discontinuation of benefits.

___ I have contacted my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.

___ I give Miss Shannon's Therapy 4 Kidz permission to submit bills for services rendered directly to the insurance carrier.

___I authorize such health insurers or other third party payers including Medicare, Medicaid, and TRICARE payment directly to Miss Shannon's Therapy 4 Kidz for services. This is a direct assignment of rights and benefits. A photocopy of this assignment shall be considered as effective and valid as the original.

___I will assist with the claims process as required by Miss Shannon's Therapy 4 Kidz or my insurance provider.

___I understand that if my insurance plan requires a deductible amount prior to coverage, I will be responsible for the full session fee until the required deductible amount has been met.

___I understand that if for any reason a collection agency is required to collect outstanding funds, I am responsible for collection fees as well.

___I understand that I may choose to pay privately in full, despite insurance benefits, for particular services and may be required by law to complete and sign additional paperwork (i.e. ABN).

___I understand that I may not duplicate services to be paid by my health insurance/Medicaid at multiple providers. I further understand that once the initial evaluation has been provided, I am no longer able to receive services from another provider. I do however have the right to choose multiple service providers when NOT requesting reimbursement from my health insurance/Medicaid.

___I understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of treatments and services unless agreed to in writing by myself and Miss Shannon's Therapy 4 Kidz.

By signing below I acknowledge that I have read and understand the Financial Policy and I hereby agree to abide by it.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

Private/Self-payment for Services

I have read and accept Miss Shannon's Therapy 4 Kidz financial policy and I agree that I will self-pay for services at Miss Shannon's Therapy 4 Kidz. I agree to the fee schedule provided to me and attached. I understand that payment for services is due at the time services are provided.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

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Consent for Billing

☐ I understand that I am responsible for all charges incurred for therapy services provided for me and/or my child. I understand that Miss Shannon's Therapy 4 Kidz bills my personal insurance as a courtesy and that I am responsible for that bill. I am responsible for keeping Miss Shannon's Therapy 4 Kidz up to date on any changes to my plan or policy.

Private and State Insurance Coverage Changes

☐ If I/my child has changes in insurance, it is my responsibility to inform Miss Shannon's Therapy 4 Kidz in advance to determine coverage and need for prior authorization.

☐ If I/my child is covered, partially or in full, by state insurance, it is my responsibility to provide Miss Shannon's Therapy 4 Kidz with updated insurance information on the first visit of every month. If I fail to do so, I/my child may not be able to be seen for that visit.

☐ For insurances that require prior authorization, I understand that there may be times when my/my child's treatment may be affected.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

Please feel free to call us at 702-970-9242 or email us at info@missshannonstherapy4kids.com with any questions or concerns.

Authorization for Credit Card Use

All information will remain confidential

Name on Card: _____

Billing Address: _____
_____ (City, State & Zip)

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ AmEx

Credit Card Number: _____

Expiration Date: _____

Identification Number: _____ (last 3 digits located on the back of the credit card)

Authorization: I authorize Miss Shannon's Therapy 4 Kidz to charge this credit card for late payments on invoices due and payments associated with any documentation, report writing and or consultation which have not been paid in due time according to the practices and policies.

Signature: _____

Print Name: _____

Date: _____

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Termination of Existing Services from Previous Provider

Use of this form is to terminate service with an existing provider to allow Miss Shannon's Therapy 4 Kidz to submit an authorization request. Miss Shannon's Therapy 4 Kidz completes this form.

Date of Request: _____ Service Type: Outpatient Therapy-Occupational Therapy
Request: Terminate Service with existing provider to allow submission of prior authorization request from Miss Shannon's Therapy 4 Kidz.
Termination date with existing provider: _____

Recipient Information

Last Name: _____ First Name:_____
Medicaid ID: _____ Date of Birth:_____
Recipient must complete the following section and sign below:
I (print child's name) _____ am requesting that services be terminated with (print name of current/terminating agency):_____.
I understand this will end my services with my current/terminating provider.
The effective date for termination is: (date) _____.
_____ Signature of Patient or Responsible Party _____Date
_____Patient Name _____ DOB _____Relationship to Patient

New Requesting Provider Information

New/Requesting Provider Group Name: Miss Shannon's Therapy 4 Kidz
Individual Representative from New Provider: _Arabella Holman_
New/Requesting Provider Agency NPI: _1275620270_
New/Requesting Provider Name: _____
New/Requesting Provider Agency Phone Number: 702-970-9242
Provider Signature: _____Date: _____

Current / Termination Provider Information

Current/Terminating Provider Agency Name: _____
Current/Terminating Provider Agency Contact Name (print name): _____
Current/Terminating Provider Agency Phone Number: _____

Services

List all services that will terminate with current provider.
HCPCS/CPT/CDT Code Description:_____End date for each service _____
HCPCS/CPT/CDT Code Description:_____End date for each service _____
HCPCS/CPT/CDT Code Description:_____End date for each service _____
HCPCS/CPT/CDT Code Description:_____End date for each service _____

Additional Details

Additional comments or contact information not specified above that would assist in the completion of this request:_____
_____
_____
_____

Miss Shannon's Therapy 4 Kidz 2449 N. Tenaya Way Unit 34991 Las Vegas, NV 89128 702-970-9242

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Authorization to Exchange, Obtain, and Release Information

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Nevada law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____ Other Name(s) Used: _____
Date of Birth: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Email (Optional): _____
Information regarding health care provider or health care entity authorized to disclose this information:
Miss Shannon's Therapy 4 Kidz (Initial. Specify if needed) _____
Information regarding person or entity who can receive and use this information:
Name: _____
Address:_____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Fax: (____) _____
Insurance Company: _____
Other: (Neurologist, pediatrician, school, nanny, family member, etc.)
Name: _____
Address:_____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Fax: (____) _____
The information to be disclosed (initial any that apply):
_____Client therapeutic process/progress _____ Date of treatment
_____ Verbal/written communication between professionals
_____ Session notes _____ Diagnosis _____ Billing information
_____ Test, assessment or evaluation results _____ Entire record
Other:
_____
Include: (Indicate by Initialing)
_____ Drug, alcohol or substance abuse records
_____ Mental health records (except psychotherapy notes)
_____ HIV/AIDS-related information (including HIV/AIDS test results)
_____ Genetic information (including genetic test results)
Reason for release of information: (Choose all that apply)
□ Treatment/continuing medical care □ Personal use □ Billing or claims □ Insurance □ Legal purposes □ School
□ Employment □ Other (specify): _____

The individual signing this form agrees and acknowledges as follows: (i) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form. (ii) Effective Time Period: This authorization shall be in effect (1) year to date from the following date: Month: _____ Day: _____ Year: _____. (iii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. (iv) Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein. (v) Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior

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to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.
SIGNATURES: Patient/Legal Representative: _____
Date: ____ Printed Name of Legally Authorized Representative (if applicable): _____
If Legal Representative, relationship to Patient: _____
Witness (optional): _____ Date: _____
A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.
Signature of Minor (if applicable): _____ Date: _____

Client Name: _____ Date of Birth: _____

Home Address: _____

The below signature releases any/all medical records past or present to Miss Shannon's Therapy 4 Kidz from other providers. In accordance with NRS 5 629.051, I understand all medical records on the above patient may be destroyed after their 23rd birthday. By signing below I am stating that I have no questions regarding this section.

_____ Signature of Patient or Responsible Party _____Date
_____Patient Name _____ DOB _____Relationship to Patient

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Teletherapy Consent

By signing below I understand and consent to engage in teletherapy for me and/or my child with Miss Shannon's Therapy 4 Kidz. Teletherapy is a form of occupational therapy services provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical health information both orally and/or visually. Teletherapy has the same purpose or intention as occupational treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities

1. My child must be a resident of Nevada.
2. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or there is a risk that services could be disrupted or distorted by unforeseen technical problems.
5. I understand that teletherapy-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be provided additional therapy options to pursue.
6. I understand that I and/or my child may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I understand that there is a risk of being overheard by anyone near me if I and/or my child are not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, and (3) being available to my child during the teletherapy session to facilitate follow through and participation. It is the responsibility of the treatment provider to do the same on their end.
8. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent. I have read, understand and agree to the information provided above regarding telehealth.

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Photo/Recording Permission

Please initial the following OPTIONAL statements:

___I give permission for photos/videos being taken for clinical use. They will be used for the purposes of evaluation, treatment, planning, mentoring, education, family communication, and documentation. These materials will only be viewed by Miss Shannon's Therapy 4 Kidz therapists and fieldwork students, the parents, and in the medical chart. In giving my consent, I hereby release and hold harmless Miss Shannon's Therapy 4 Kidz, their employees, agents, and designees from any and all responsibility or liability.

___I give permission for photos/videos being used for promotional materials for Miss Shannon's Therapy 4 Kidz. This may include social media, flyers, advertising, brochures, and/or website. I will be shown materials for approval before publication. In giving my consent, I hereby release and hold harmless Miss Shannon's Therapy 4 Kidz their employees, agents, and designees from any and all responsibility or liability. I understand that I will NOT receive compensation should any photographs/recordings of myself/my child be used.

___I do NOT give permission for photos/videos being taken.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

Technology Permission

___I authorize Miss Shannon's Therapy 4 Kidz to call my home or alternate location and leave a message regarding appointments or insurance/payment questions.

___I authorize Miss Shannon's Therapy 4 Kidz to mail any items that assist in the plan of care (appointment reminders, patient statements, home programs, etc as long as they are labeled "Personal and Confidential".

___I authorize Miss Shannon's Therapy 4 Kidz to email/text me information such as appointment reminders and patient statements.

Please initial the following OPTIONAL statements:

___Email: I give permission to Miss Shannon's Therapy 4 Kidz to correspond with my child's parents and/or legal guardians and treatment team via email regarding treatment, documentation, communication, scheduling, and home activities. I understand that Miss Shannon's Therapy 4 Kidz email is encrypted internally, however, once sent, email may be susceptible to interception by outside parties.

___Text: I authorize Miss Shannon's Therapy 4 Kidz to send text messages and photos to my cell phone related to my child's treatment. In doing so, I understand that text messaging is not secure and may be susceptible to outside party interception. I understand that all standard data and text messaging rates may apply. I agree not to hold Miss Shannon's Therapy 4 Kidz liable for any charges or fees generated by text messaging.

Consent for Participation with Therapeutic Equipment/Activities

Therapy services with Miss Shannon's Therapy 4 Kidz may include various specialized therapy/playground equipment including, but not limited to, swings, slides, bolsters, physioballs, climbing structures, sensory bins/items (seeds/grains, wood shavings, stones, marbles; play dough, putty, kinetic sand, slime, lotion, shaving cream, etc), craft items (paint, glue, crayons, etc); food exploration/play, and a variety of other sensorimotor activities. Miss Shannon's Therapy 4 Kidz will strive to ensure each child's safety. I am aware of the inherent risk of these activities, and I give permission for my child to participate in therapy.

*Known Allergies and/or Contraindications for Use:*_____

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Cancellation/No Show/Tardy/Late Pick Up Policies

Miss Shannon's Therapy 4 Kidz is dedicated to providing the best pediatric services possible. However we are not able to do this alone and require your assistance to facilitate the best use of therapy time while providing complete and consistent care for you and your child. As we have discussed previously, continuity of care is vital to the success of your child's therapy. Please discuss schedule changes at the end of your session and/or text or email your therapist or the office for changes. This will allow our conversation to focus on therapy and your advance notice will allow us to schedule others into our additional openings. Please be available the last 5 to 10 minutes of your child's session so that we can review our session, discuss concerns/progress, and review home activities.

Cancellation/No Show/Tardy:

☐ I understand that any cancellation, not due to illness or family emergency, must be made by notifying the treating clinician 24 hours in advance or no later than 7 am on the day of service. Failure to cancel without 24 hours notice will result in a charge of $30.00, this fee is not reimbursable by insurance and is my responsibility. This fee must be paid prior to the next appointment. Miss Shannon's Therapy 4 Kidz reserves the right to dismiss a client from therapy for inconsistent attendance and withhold all test results and reports when professional fees are not paid. An appointment that is rescheduled within the same week is not considered a cancellation.

☐ I understand that if my child has 3 consecutive cancellations or misses more than 20% of his/her scheduled appointments, my child may lose his/her standing appointment time and may be placed on hold for therapy. A letter will also be sent to my primary care physician.

☐ I understand that Miss Shannon's Therapy 4 Kidz requires an 80% attendance rate and that my child may be removed from the schedule if this is not maintained. Miss Shannon's Therapy 4 Kidz calculates attendance quarterly and will make all attempts to notify me if my attendance falls below 80%. Please communicate with Miss Shannon's Therapy 4 Kidz to avoid scheduling issues.

☐ I understand that if therapy needs to be canceled for more than 2 weeks due to vacation, after school programs, community sports, etc, that Miss Shannon's Therapy 4 Kidz will hold my appointment during said timeline and fill with other patients.

☐ I understand that if my child missed a scheduled appointment and I did not call to indicate a cancellation, my child will be considered a "no show". This will result in a $30.00 no show fee, this fee is not reimbursable by insurance and is my responsibility. This fee must be paid prior to the next appointment. If my child has 2 consecutive no-shows my child will be placed on hold until scheduling is resolved. If a resolution is not made within 5 business days, my child will lose his/her therapy time and be placed on Miss Shannon's Therapy 4 Kidz wait/cancellation list and a letter will be sent to my primary care physician.

☐ I understand it is my responsibility to communicate to the front desk and/or my therapist any schedule changes or appointment cancellations.

Please feel free to contact use regarding your appointment schedule if it is not optimal as we will do everything possible to provide a time that works with your family and provides continuity of care for your child.

Late Start/Late Pick Up:

☐ Late Start Policy: Late arrivals will not be accommodated by extending therapy time, and full session fees will apply. For example: If your child is 5 minutes late to their scheduled appointment time, the result will be a 30-minute session fee, even though it was only a 25-minute therapy session. If you are more than 15 minutes late and did not call in advance, your child may not be able to be seen.

☐ Late Pick-up Policy: Parents are expected to be available prior to the end of their child's therapy session as it is vital for parent education, session review, and home activity review. **Late pick-up fees are not eligible for insurance reimbursement and must be paid at time of pick up. Failure to pay late fees prior to next session may result in suspension of services.**

Miss Shannon's Therapy 4 Kidz late pick-up policy is as follows: Each family will receive 2 free passes (no fee assessed) for late pick up (not to exceed 5 minutes) per calendar year. Late pick-ups beyond 5 minutes or after the use of the two "passes" will be charged by the quarter-hour at the standard individual therapy rate: 5 to 15

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minutes $25.00; 16 to 30 minutes $50.00; 31 to 45 minutes $75.00; and 46 to 60 minutes $100.00. Ongoing lateness may result in parent required to remain in clinic and/or suspension from services.

By signing below I acknowledge that I have read and understand the above policies on cancellations, late start, late pick up, no show, and attendance and hereby agree to abide by them.

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Well/Sick and Post-Surgery/Hospital Policies

The health and wellness of your child, your family, other patients and families in our care, and our staff is of utmost importance to Miss Shannon's Therapy 4 Kidz. Please do not be offended if we feel your child is too sick to participate in therapy and ask you to take your child home. We thank you for your understanding.

In order to ensure the health and well-being of everyone please read the following.

☐ I understand that my child will not receive services if he/she arrives with any of the below stated symptoms and/or will be dismissed from session early if symptoms present themselves during the session.

☐ I understand that my child's session may end early if my child does not appear their usual self and/or is not participating in the session.

☐ I understand that my child must be symptom free without the use of medication, including Tylenol, for 24 hours prior to returning/resuming therapy.

☐ I understand that if my child goes to the doctor and is prescribed medication, please I am to keep him/her home until they have completed 24 hours of medication.

☐ I understand that it is my responsibility to inform the staff at Miss Shannon's Therapy 4 Kidz as soon as possible if my child has been exposed to a contagious illness so that they may alert families and staff to possible exposure while protecting my child's identity. This may include posting a notice, sending email/text messages, and therapist report to families.

☐ I understand that I may be asked to provide a physician's note to resume therapy following a contagious and/or infectious condition.

My child may not receive therapy services at Miss Shannon's Therapy 4 Kidz if he/she presents with:

- fever of 100 degrees or higher with/without other symptoms
- nasal, ear, and/or eye discharge that is not clear with/without fever
- persistent/hacking cough with/without fever
- cold with/without fever
- upper respiratory illness such as bronchitis or influenza
- Covid symptoms with/without fever
- sore/strep throat with/without fever
- earache/headache with/without fever
- vomiting/diarrhea (3 or more episodes within a 24 hour period) with/without fever
- marked drowsiness or malaise
- swollen glands around jaws, ears, and neck
- any other symptoms suggestive of acute illness
- pink eye
- lice
- chicken pox with/without fever
- unknown/contagious rash with/without fever
- any skin lesion in the weeping stage
- contagious illness
- any communicable disease

If your child has had a rough night/day and/or is not engaging in their normal routines they may need to stay home. Please don't hesitate to call and ask us if you have any doubts.

We will be happy to resume therapy earlier if accompanied by a physician's note releasing your child back to therapy as no longer contagious.

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Hospital and/or Surgery

☐ I understand that if my child is hospitalized for any reason, I will be required to provide and physician's release to resume therapy services.

☐ I understand that if my child undergoes any surgery, I will be required to provide a surgeon/physician's release to resume therapy stating condition of return (such as with/without limitations/precautions).

☐ I understand that if I arrive with my child to therapy without the physician's release my child will not receive services.

By signing below, I acknowledge that I have read and understand the policies on illness/wellness, hospitalizations, and surgery and hereby agree to abide by them.

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Clinic/Home/Community Etiquette

Miss Shannon's Therapy 4 Kidz wants our environment to be one of family, fun, welcome, and comfort. To ensure that everyone feels welcomed, we have created the following policies. Please let us know if you have any comments or concerns regarding our space.

In the Clinic:

☐ I understand that when I am in the lobby and/or clinic I will be asked to wear a mask.

☐ I understand that children in the lobby must be accompanied by an adult at all times.

☐ I understand that I may choose to wait in my car and call my therapist and/or front desk to check in and that my therapist will come to me to pick up and drop off my child. I understand I need to acknowledge my therapist in some way so they know my car.

☐ I understand that it is my responsibility to share concerns, updates, and information with my child's therapist at time of pick up (from car or waiting room).

☐ I understand that I if I chose to leave the clinic, that I must be in the parking lot or waiting room 5 to 10 minutes prior to the end of my session.

We welcome you to be a part of your child's therapy session as active parent participation in therapy is critical for progress and carryover of skills. However, we are also aware that some children just do better if parents are not watching. If this is the case we will collaborate on how to best include you in your child's session. We also know that we are not just treating your child, but may need to work with your child and their siblings; this will be arranged in advance with your therapist.

In the Treatment Space:

☐ I understand that if I participate in my child's session I will be asked to wear a mask and remove my shoes once in the treatment space.

☐ I understand that I am not to enter the treatment space without my child's therapist or a clinic escort and I am to remain in the same room as my child during their session.

☐ I understand that I am to silent my phone/tablet and to limit sibling interactions on devices to child appropriate themes/content.

☐ I understand that my conversations may not be private and topics and content need to be child-friendly.

☐ I understand that the last 5 to 10 minutes of my child's session are for review and exiting and it is my responsibility to bring up questions, concerns, problem-solving, etc during the session. If my therapist is unable to address my inquiries at that time, he/she will arrange another time for discussion.

☐ I understand that it is my responsibility to bring a diaper bag with diaper and clothing changes for my child as the clinic does not have any supplies on site.

☐ I understand, that at my request, my therapist will work with my child on toileting skills; however this will not occur until I have been present with my therapist and child to review how we address toileting to ensure the safety and comfort of my child. This applies to diaper changes as well.

☐ I understand that I can choose to not have my therapist assist in toileting/diapering of my child, but in doing so I must remain at the clinic (in my car or in the lobby) to be available.

☐ I understand that toys from home are not to come to therapy unless requested by my therapist. If my child requires a transitional item, my therapist will work with me to facilitate smooth transitions.

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☐ I understand that due to food allergies, restricted diets, and food aversions that I am not to bring outside food into the lobby. If my therapist requests food for my child's session, this will be requested in advance and will be used in the treatment space.

☐ I understand that I may take photos/video of my child in their session only when no other children are present.

☐ I understand that HIPAA prohibits the staff of Miss Shannon's Therapy 4 Kidz from answering any questions I may have of other clients and families at the clinic.

In the Community/In my Home:

☐ I understand that if my child is receiving home services that a parent must remain in the home. Just as in the clinic I may or may not participate in my child's session.

☐ I understand that my therapist will use both items/resources from my home (at my discretion) as well as bring their own items/resources.

☐ I understand that a home session does not automatically include siblings and/or other family members in the therapy session, this will be discussed in advance for both home and community visits.

☐ I understand that if we are meeting in the community, I am responsible for my child's transportation to/from as well as remaining on the premises.

☐ I understand that my therapist will provide all therapy items for the community unless arranged in advance with me.

☐ I understand that my therapist will work hard to protect my child's privacy while in the community, but due to the nature of a community visit, is not able to guarantee privacy and I will not hold my therapist and/or Miss Shannon's Therapy 4 Kidz liable.

☐ I understand that my therapist will request a signature on my child's Attendance Form for record of session.

As your team of therapists, you can expect us to:

Be masked.
Begin and end your appointments in a timely manner.
Ensure that you know and understand your child's goals as well as your child's progress made during each session.
Collaborate with you to provide strategies that work for you and your family to facilitate home activities and session carry over.
Collaborate with you to provide strategies that facilitate ease of home and community participation/life.
Respect and honor your home as would be expected of a guest.
Honor your trust with confidentiality.
Provide the best therapy we know how.
Ensure professionalism when addressing scheduling and billing questions and concerns.
Ensure courteous and friendly interactions with you and your child.
Create a fun, welcoming, and safe therapy environment for you and your child.
Accept compliments, complaints, and feedback in a gracious manner and acknowledge, address, and resolve in a timely professional manner.

If you have any questions please reach out to us. By signing below, I acknowledge that I have read and understand the Clinic/Home/Community Etiquette Policies and hereby agree to abide by them.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

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CONSENT FOR EMERGENCY MEDICAL TREATMENT

Patient's name: _____ Date of birth:_____

Mother's Phone: Cellular _____ Work _____ Home _____

Father's Phone: Cellular _____ Work _____ Home _____

In case of an emergency and if I/We are not present and cannot be reached to make arrangements for emergency medical attention, at the phone numbers provided above and/or on my child's information form:

☐ I/We authorize Miss Shannon's Therapy 4 Kidz to take my child to the location listed below, or to the nearest hospital, and give permission for Miss Shannon's Therapy 4 Kidz to consent to the medical treatment recommended by the licensed physician or dentist under the provisions of the Medical or Dental Practice Act. I/We understand that Miss Shannon's Therapy 4 Kidz will not be liable for any first aid treatment, medical, medications, or surgical procedures rendered pursuant to this consent.

Doctor:_____ Address:_____ Phone:_____

Please inform medical staff that my child has the following allergies and/or takes the following medications for said allergies and/or on a regular basis:

Allergies: _____

Medications: _____ Use and Dosage: _____

Please list 2 additional people who Miss Shannon's Therapy 4 Kidz may contact in the event of an emergency.

Name: _____ Number: _____ Relationship to Child: _____

Name: _____ Number: _____ Relationship to Child: _____

☐ I/We understand that Miss Shannon's Therapy 4 Kidz will call 911 or other appropriate medical personnel if deemed necessary. I/We give permission for Miss Shannon's Therapy 4 Kidz to consent to the medical treatment recommended by the licensed physician or dentist under the provisions of the Medical or Dental Practice Act. I/We understand that Miss Shannon's Therapy 4 Kidz will not be liable for any first aid treatment, medical, medications, or surgical procedures rendered pursuant to this consent.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES

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Compliments, Complaints and Other Feedback

Your feedback, both positive and negative gives us valuable information on how we are doing and your satisfaction with our services. We take your information seriously and view it as an opportunity for learning and improvement. We treat your information with confidentially (unless your permission is obtained) and sensitivity. Please contact us in person, by phone at 702-970-9242; by email at missshannon@missshannonstherapy4kidz.com; or in writing to 2449 North Tenaya Way, Unit 34991, Las Vegas, NV 89128. Your feedback will be formally acknowledged within 2 business days. We strive to respond to and resolve (if needed) within 28 working days. All feedback provided will be used by Miss Shannon's Therapy 4 Kidz to improve our practice. Miss Shannon's Therapy 4 Kidz will seek feedback as well via satisfaction surveys, feedback to staff following interactions, and in collaborations for treatment plan and service delivery.

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Acknowledgement and Assumption of Risks

I, _____ (parent/guardian name) of _____(child's name) understand that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to have _____ (child's name) receive therapy services from Miss Shannon's Therapy 4 Kidz and/or any employee or independent contractor employed by Miss Shannon's Therapy 4 Kidz.

I acknowledge that there are some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries. Some of the unlikely but potential injuries may include: Injury secondary to falls, communicable infections/viruses, allergic reactions to equipment/materials, mild skin abrasions and bruising.

I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Miss Shannon's Therapy 4 Kidz and/or any employee or independent contractor employed by Miss Shannon's Therapy 4 Kidz accountable for any losses, injuries or other damages occurring to my child and/or myself. I further understand that I am fully responsible for my own safety.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

Liability Waiver and Release

I understand the therapy offerings and expectations coordinated and provided by Miss Shannon's Therapy 4 Kidz and consent to the use thereof in providing treatment for my child. I acknowledge that it is my responsibility to inform my child's physician that my child is participating in this treatment. I confirm that my child's physician is aware of my child's participation in pediatric therapy services. I voluntarily request that Miss Shannon's Therapy 4 Kidz provide treatment for my child. I acknowledge the risks / potential risks of engaging in the pediatric therapy program, which are similar to the risks of play and activities of daily living. After considering the inherent risks, I feel that the possible benefits are greater than the possible risks. I voluntarily assume the risk for my child. I hereby as parent or legal guardian intending to be legally bound, for myself, my heirs and assignees, executors or administrators, waive and release forever any and all claims for damages against Miss Shannon's Therapy 4 Kidz, its therapists, volunteers, employees, referring entities, subcontractors, property owners upon whose land the services are conducted, for any and all injuries and / or losses I or my child may sustain while voluntarily participating in the pediatric therapy program. I understand that Miss Shannon's Therapy 4 Kidz wishes to take reasonable steps to maintain the safety and well being of its participants. I confirm that I have disclosed all medical conditions of my child that may be affected in any way by the treatment. I acknowledge that I am responsible for updating this release if the medical condition of my child changes. I acknowledge that I have been given sufficient time to ask questions, if any, concerning the nature and scope of this agreement. I have read the entire agreement and agree to it.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

*DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Miss Shannon's Therapy 4 Kidz
2449 N Tenaya Way Unit 34991
Las Vegas, NV 89128
1(702)970-9242
Info@missshannonstherapy4kidz.com

Socks Yes Shoes No Policy

Miss Shannon's Therapy 4 Kidz has a no shoes policy in the treatment space. This is limit the amount of environmental debris tracked in from the outside being deposited on our floors and mats. We and your child can often be found on the floor working in many postures and movement patterns.

Socks however are required. This is again in an effort to help keep the floors as clean as possible.

You may see some therapists/staff wearing shoes, these are for our comfort and support and are shoes that are left in the clinic and never worn outside. If you would like the same for your child, please feel free to bring in a pair of clean, never worn outside shoes that we will be happy to label and keep in the clinic for your child.

You may see some children wearing shoes. These children will also often be wearing braces and their shoes are needed to provide stability and safety while they walk. We do our best to wipe down these shoes prior to entry into the treatment space.

Please feel free to ask if you have any questions. Thank you for your understanding in this matter.

_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

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Insurance Verification Form

Date: _____

Name: Last _____ First _____ Middle Initial_____

Birth Date: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Policyholder's Information

Primary Insurance:

Name: Last _____ First _____ Middle Initial_____

Birth Date: _____ Gender: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Carrier: _____

Member ID #: _____ Group #: _____

Secondary Insurance:

Name: Last _____ First _____ Middle Initial_____

Birth Date: _____ Gender: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Carrier: _____

Member ID #: _____ Group #: _____

Please initial the following statement:

_____ I DO NOT YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED.

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HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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

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.

You have the right to:

Get a copy of your health and claims records.

- You can ask to see or get a copy of your health and claims records 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 and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records.

- You can ask us to correct your health and claims records if you think they are 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 consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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

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.
- 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.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission.

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive.

- We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization.

- We can use and disclose your information to run our organization and contact you when necessary. Example: We use health information about you to develop better services for you.

Pay for your health services.

- We can use and disclose your health information as we pay for your health services. Example: We share information about you with your therapy plan to coordinate payment for your therapy services.

Administer your plan.

- We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director.

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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.

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, on our web site, and we will mail a copy to you.

June 15, 2022

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Front of File Form

ALL CLIENTS

Child's Name: _____ Date of birth: _____

Parent Name(s): _____

Parent Mobile Number(s):_____

Nanny/Other Number:_____

My child is ☐ or is not ☐ allowed to receive snacks during treatment sessions. (check one)

Miss Shannon's Therapy 4 Kidz has a variety of snack options. All of our snacks are nut-free and we do stock gluten-free selections. Please list any allergies or food restrictions:

_____

_____

List any emergent health concerns such as seizures: _____

_____

Describe the health plan required to address those health concerns: _____

_____

_____

_____

_____ Parent Signature _____ Date

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