12010 Etris Rd. Suite A-150, Roswell, GA 30075 Phone: 770-998-9599 FAX: 770-645-1313

Cobblestone Therapy Group

Patients Name: _____ Date of birth: ____/____/____ Sex: ☐M ☐F

Address: _____ City: _____ State: _____ Zip: _____

Previous Diagnosis/Reason for visit: _____

Today my child is here for:
☐Speech Therapy ☐Occupational Therapy ☐Feeding Therapy ☐Hearing Screening (available for age 3 and older)

School/Daycare: _____ Grade/Teacher: _____

Who referred you to Cobblestone?: _____

Parent/Caretaker Name(1): _____ Relationship to child: _____

Primary Phone #: _____ Alternate Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____

Parent/Caretaker Name(2): _____ Relationship to child: _____

Primary Phone #: _____ Alternate Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____

Pediatrician/Primary Care Physician: _____ **Pediatrician phone:** _____

Pediatrician Fax: _____ **For office use only→ NPI:** _____

Insurance Company Name: _____ Member ID number: _____

Group Number: _____ Phone Number for Providers: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Name (2): _____ Member ID number: _____

Group Number: _____ Phone Number for Providers: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Food Allergies: _____

Emergency Contact: _____ Emergency Contact phone: _____

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Brothers, sisters, and/ or others residing in home:

Name:	Age:	School:
1.		
2.		
3.		
4.		
5.		

List any immediate family with a history of speech, language, and/or hearing problems. Describe these problems:

What language(s) does the child speak?:_____ primary language:_____

What languages are spoken in the home?_____

With whom does the child spend most of his or her time?:_____

SPEECH THERAPY REFERRAL:

Briefly describe the child's speech language difficulty (if any):_____

How does the child usually communicate (gestures, single words, short phrases, sentences)?:_____

When was the problem first noticed?_____. By whom?_____

Is the child aware of the problem? **Circle** Yes No. If yes, how does he/she feel about it?_____

Have any other speech-language specialists seen the child? Who and When? What were their conclusions or suggestions?

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OCCUPATIONAL THERAPY REFERRAL:

Briefly describe your concern:_____

_____

_____

When was the problem first noticed?_____. By whom?_____

Is the child aware of the problem? **Circle** Yes No. If yes, how does he/she feel about it?_____

Have any other occupational therapists seen the child? Who and When? What were their conclusions or suggestions?

FEEDING THERAPY REFERRAL:

Briefly describe the child's feeding difficulty (if any):_____

_____

What are the child's current typical feeding behaviors?_____

_____

When was the problem first noticed?_____. By whom?_____

Is the child aware of the problem? **Circle** Yes No. If yes, how does he/she feel about it?_____

Have any other feeding specialists seen the child? Who and When? What were their conclusions or suggestions?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, ect.)? If yes, please describe:

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Medical History/Information:

Mothers general health during pregnancy:_____

Describe an illnesses or accidents during pregnancy:_____

Describe any unusual problems during or immediately following birth (length of labor, cesarean or breech birth, jaundiced, oxygen required ect):_____

_____

Infants general condition at birth:_____

Describe an abnormalities, health problems, or feeding problems noted during the first weeks of life:_____

Developmental History- Please give the best age approximation at which the child began to do the following:				
Crawl:	Sit alone unsupported:	Stand:	Engage in a conversation:	Put two words together (e.g. mommy shoe, doggie run, ect.):
Walk unaided:	Feed self:	Dress self:	Use short sentences:	
Use toilet:	Respond to name:	Said first word:	Consistently use single words:	

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle contraction?:_____

Please circle:
Does the child respond to all sounds? YES NO
Does the child respond to loud sounds only? YES NO
Is the child inconsistent with his/her responds to sound? YES NO
Date of most recent hearing evaluation/ screening_____ **Passed or Failed (circle one) or N/A**☐

At what approximate ages did the following illnesses, conditions, and/or procedures occur?			
Adenoidectomy:	Rheumatic Fever:	Tinnitus:	Asthma:
Chicken Pox:	Chronic Colds:	Convulsions:	Dizziness:
Tonsillectomy:	Diphtheria:	Whooping Cough:	Croup:
Ear Infections:	Encephalitis:	German Measles:	Influenza:
Headaches:	Head injuries/Trauma:	High Fever:	Allergies:
Sinus infections:	Mastoiditis:	Tonsillitis:	Measles:
Meningitis:	Venereal Disease:	Myringotomy & Tubes:	Mumps:
Pneumonia:	Scarlet Fever:		

Describe any surgeries:

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Describe any major accidents or hospitalizations:

Does the child sleep well?	**Eat well?**	**Play Alone?**
Play with other children?	**Age of playmates:**	
Does the child get along well with other children?		
Describe any discipline problems:		
Difficulty concentrating?:		
Favorite play activities/ interests?:		
What are your child's strengths?		
Describe any evaluations or therapy for behavioral or emotional problems:		

List all educational settings attended (nursery, kindergarten, day care, special classes, ect.):

How is the child doing academically (or pre-academically) ?:

Does the child receive special services? If yes, describe:

Is your child currently taking medications (if yes, please list):_____

_____

Any Additional comments?

Parent's or Guardian's Signature:_____ **Date:**_____

Patient Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Please note that the term "you" in the following document is means "you the patient, guardian, or parent of the patient." The terms "we" and "us" shall refer to Cobblestone Pathways, LLC, DBA "Cobblestone Therapy Group".

In accordance with federal law, the following Patient Privacy Notice is used to communicate the way in which medical information about you may be used and disclosed. Also included in this document is how you can access this information.

As the provider of medical services, we may require your written consent before we use or disclose medical information for purposes including but not limited to the following:

- Providing or arranging for healthcare services related to you
- Payment or reimbursement for the care provided to you
- Related administrative activities supporting your treatment.

There are cases in which we may be required or permitted by law to use and disclose your medical information without your consent or authorization.

Each patient of Cobblestone Therapy Group retains important rights regarding their medical information. The following list includes, but is not limited to the right retained by you:

- Inspect, copy, amend, or correct your medical information that we maintain
- Obtain an accounting of our disclosures of your medical information
- Request confidential communication with you
- Request restrictions on specific uses and disclosures of your health information
- File a complaint if you believe your rights have been violated
- Be notified of any breach containing Private Health Information

A detailed version of our Notice of Privacy Practices is included and available to fully explain your rights and our obligations under the law. The Notice may be revised periodically and is available on paper or electronically upon request. The most recent update to the Notice is located in the top right hand corner of this document.

Any questions, comments, suggestions, or complaints regarding the Notice of Privacy Practices and your medical information should be either directed to our Privacy Officer, Alyssa Yount, at 770-998-9599 and/or to the Secretary of the Department of Health and Human Services (DHHS).

ACKNOWLEDGEMENT:
I acknowledge by signing below that I have received and read or had explained to me this Notice of Privacy Practices for Cobblestone Therapy Group

Child's Name: _____

Parent/Legal Guardian: _____

Date: _____

CLIENT NAME: _____

Assignment of Benefits/Release of Information

I hereby request that payment of authorized Medicaid, and/or health insurance plan benefits be made on my behalf to Cobblestone Therapy Group for therapy services provided. I authorize Cobblestone Therapy Group to release to my third party payer / insurer and/or to the Health Care Financing Administration and its agents, if necessary, any medical information needed to determine the benefits payable for related services.

I understand that I will be personally responsible for any amount denied, or any remaining amount owed for services partially covered or not covered by my third party payer/insurer.

Patient/Guardian _____ Date _____

No, I wish to file insurance on my own behalf.

Patient/Guardian _____ Date _____

Consent regarding health information sent electronically

I understand that messages sent via email may not be secure. I understand that I have the right to request information to be sent in other means (telephone, mail) if I request in writing or do not consent to email communications on this form.

_____ I give my consent to have private health information sent to me via email.

_____ I do not consent to have private health information sent to me via email.

_____ I consent to use of my email to provide reminders of upcoming appointments or events not related to my specific health information.

Patient/Guardian _____ Date _____

Email address(es) _____

_____

FINANCIAL POLICY FOR COBBLESTONE THERAPY GROUP, LLC

Cobblestone Therapy Group, LLC (hereafter referred to as "Cobblestone") shall provide speech and language, or occupational therapy services, and in return for those services, the Financially Responsible Person (as indicated by signature below) shall pay: an hourly rate of ($240.00 per hour for speech language therapy services and $320.00 for occupational and physical therapy services) (the "hourly rate"). The hourly rate may be changed subject to at least thirty (30) days prior written notice of such change.

Cobblestone will bill the insurance carrier of the Financially Responsible Person as part of its services. However, the Financially Responsible Person (as indicated by signature below) acknowledges that the financial obligation described herein is unconditional, and if the insurance company does not remit payment to Cobblestone within sixty (60) days of the date the request for payment was submitted, the full balance will be due from the Financially Responsible Person. In the event that the insurance company requests a refund of payments made after they have been paid to Cobblestone, the Financially Responsible Person will be responsible for the amount of money refunded to the insurance company. In the event the insurance company establishes an internal usual and customary fee schedule, the Financially Responsible Person will be responsible for any shortfalls.

If payment is made directly to the patient, or the Financially Responsible Person for services billed by Cobblestone, the Financially Responsible Person shall either: (1) promptly remit such payment for services to Cobblestone with an explanation of benefits (EOB) with endorsement made and reassigned to provider; or (2) remit payment to Cobblestone in the full amount received by the insurance company along with any explanation of benefits (EOB) provided to patient or Financially Responsible Person.

A charge of $40.00 per 30-minute visit and $80.00 per one hour visit will be billed for all cancellations and/or "no-shows" occurring without a 24-hour notification. If the patient is sick and needs to cancel, a letter from the child's physician will be required in order to waive the fee.

Payments are due each month upon receipt. Payments not received by the 22nd will be subject to a late charge of one and one-half percent (1.5%) per month (or portion thereof) compounded monthly until paid.

If Cobblestone takes any legal action to collect any amounts due from Financially Responsible Person for services provided, all legal fees, court costs, and other related expenses in their entirety which are incurred by Cobblestone will also be due upon submission of appropriate documentation, notwithstanding the lack of prior notice to the undersigned as to the amount of fees, court costs, and related expenses.

By my signature below I hereby agree to be financially responsible for all of the Child's financial obligations hereunder.

FINANCIALLY RESPONSIBLE PERSON

Date:_____ Name:_____

Consent to Use or Disclose Health Information

I authorize Cobblestone Therapy Group to use and disclose my medical information for the purposes of Treatment, Payment and Health Care Operations.*

*Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.
*Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
*Health Care Operations includes the necessary administrative and business functions of our office.

I further authorize Cobblestone Therapy Group to use and disclose the following specific health and medical information for the below listed purpose(s):
Specific medical information consisting of: therapy evaluation, assessment, progress notes and transition/home plans.

For the specific purposes of: collaboration of services with: Speech and Language pathologists, Physical Therapists, Occupational Therapists, BCW Service Coordinators & Staff, Psychologists, and/or Physicians, and authorized business office personnel.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Cobblestone Therapy Group has already used or disclosed the information in reliance on this Consent.

Patient/Guardian _____ Date: _____

If Cobblestone Therapy Group is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may review Cobblestone Therapy Group's "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in

our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Cobblestone Therapy Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Cobblestone Therapy Group I understand that diagnosis or treatment of me by Cobblestone Therapy Group may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Cobblestone Therapy Group is not required to agree to the restrictions that I may request. If Cobblestone Therapy Group agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Cobblestone Therapy Group has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Cobblestone Therapy Group's Notice of Privacy Practices prior to signing this document.

The Cobblestone Therapy Group's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Cobblestone Therapy Group.

The Notice of Privacy Practices for Cobblestone Therapy Group is also provided in the office and will be on the Cobblestone Therapy Group website www.cobblestonetherapygroup.com. This Notice of Privacy Practices also describes my rights and the duties of Cobblestone Therapy Group with respect to my protected health information.

Cobblestone Therapy Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the Cobblestone Therapy Group's office and requesting a revised copy be sent in the mail or brought to me at the time of my next appointment.

_____ _____

Printed Name of Patient or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (i.e., mother, father, etc.)

Babies Can't Wait (BCW) Financial Policy

__ I authorize Cobblestone Therapy to bill BCW for services as outlined in the IFSP.

__ I decline the BCW services and billing effective today's date going forward.

__ This is not applicable as we are not part of Babies Can't Wait.

Although we bill BCW (if authorized) and/or your insurance carrier as part of our services, you remain responsible for the entire bill when services are rendered. We require that arrangements for payment or your estimated share be made upon receipt of your bill. If BCW and/or your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same amount to us by forwarding the actual payment with explanation of benefits to our office, with endorsement made and reassigned to provider.

By coming to our office for treatment, I understand and agree that I am declining services from Babies Can't Wait and accept financial responsibility of services rendered by Cobblestone Therapy Group.

A charge of $25 per ½ hour visit will be billed for all cancellations and/or "no-shows" occurring without a 24-hour notification. If you or your child are sick and need to cancel, a letter from your or your child's physician will be required in order to waive this fee.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I have read the above information and understand my responsibility for the payment of my account.

Any changes to this agreement must be requested in writing and changes will not be retroactive.

Patient/Guardian _____ Date: _____

Cobblestone Therapy Group

Document of Mutual Understanding
Effective 1.16.2014

Welcome to Cobblestone Therapy Group. We are excited to be working with your family to improve the communication of your child. Our company was founded with the goal of enhancing the lives of our patients and their loved ones through communication improvement. We believe that the best way to accomplish this goal is through data driven, evidence based therapies, combined with compassion and love. Each child is unique and deserves a custom treatment plan that is based on an accurate diagnosis and data driven results. Our company strives to treat each person as though they are part of our own family, going above and beyond what many traditional clinicians are willing to do.

Because each family we are involved with is so important to us, we are committed to only serving those who we believe are a good fit and can benefit from our services. The ultimate success of any treatment program depends not only on the one on one time with the clinician and patient, but also involves a commitment from the family. In order for us to become a successful team and produce the desired results, it is imperative that we have a mutual understanding of expectations from the very beginning.

Please read over the information, initial, and sign where indicated. The information that follows is meant to ensure that the expectations between Cobblestone Therapy Group and our clients are aligned. If you have any questions feel free to let us know. We look forward to our future success together!

Sincerely,

Heather Taylor and Alyssa Yount
Co-Founders

I. Consistency In Service Provision: In order to ensure consistency in service provision during expected or unexpected clinician leaves of absence (professional conference, sick leave, personal leave, etc.), we as a team will be on standby to serve our fellow clinicians' families. As such, you may find that another therapist upon arrival may lead your session. You will receive a cancellation call as soon as possible in advance of your session if there are no other clinicians available during your session. Please feel free to get to know each one of our therapists as you visit Cobblestone. You may find us observing one another during sessions, we love to broaden and enhance or professional skills by learning from each other! Initial here_____

II. Cancellations: In order to ensure consistency in service provision, we need your support, particularly with late cancellations and "no shows." When there is a late cancellation or a "no show," and the clinician is at the clinic prepared and waiting, we will need to charge for the session. The rates that will be charged are $40.00 for a late cancellation/no show of a 1/2-hour session and $80.00 for a 1-hour session. We will need to have a credit card on file and will run this charge on the date of service. This ensures that our clinicians will still have an opportunity to receive payment for their time and service in preparation. If you are unable to attend your session, we ask that you provide us in well in advance if possible and with no less than 24 hours notice. This time frame will allow us to contact a family who is on standby for that time slot or on a waiting list for an evaluation or services. Initial here_____

III. Family Expectations: Each one of our clinicians consults with the client's family to create a solution for each of our clients by completing thorough evaluations, pinpointing diagnoses, and setting realistic and

functional goals using data driven, evidence based methods and modalities. We believe that in order to be successful, our clinicians, parents, loved ones, and clients are and must be committed to success. Ongoing consultation between clinician and parent/caregiver before, during, and/or after each treatment session is crucial. Please let your clinicians know how we can continue to help you bridge your child's progress during therapy sessions into the home, school, and community settings. Initial here_____

IV. Billing: Cobblestone Therapy Group accepts payment from Medicaid, insurance and private pay. Clients will be responsible for all payments of services in the event insurance or Medicaid claims are denied. Co-pays and deductibles are due on the date and time services are rendered. We ask for payment upon arrival to the clinic and that a credit card be on file for off-site clients and in the event of missed co-pays. Parents/Caregivers are responsible for informing Cobblestone Therapy of any billing or insurance changes. Failure to do so may result in a $10 per claim re-submission and payment in full for each session denied by insurance for untimely filing due to parent/caregiver failure to report insurance changes in a timely fashion. Lastly, in the event that an insurance company fails to pay authorized claims, we ask the parents/caregivers get involved to assist with payment collection. All billing questions should be directed to Jennifer Norton and/or Marsha England at 770-998-9599. Initial here _____

V. Preparation: Due to the nature of our practice, it is not uncommon for sessions to run behind schedule; however we ask that the patient be prepared for therapy at the scheduled time. Habitual failure of client preparedness at the time of therapy may result in the discontinuation of services. Initial here _____

VI. Therapy Session: Therapy sessions are conducted with a limited amount of time and every minute is crucial. Although the majority of time during therapy may be directly with the clinician and patient, we do encourage parent participation when prompted. The clinician must be in control of the therapy session at all times. We ask that any questions that come up during a session be held until after therapy has concluded. Please note that our clinicians are generally visiting other patients that day and may need to schedule a separate time to discuss any in depth issues. Initial here _____

VII. Periodic Reviews: As part of our service offering, we incorporate periodic reviews with the clients and/or parents. These reviews will allow for the clinician to review goals and make any necessary changes. Initial here _____

VIII. Privacy: The privacy of our clients is of utmost importance. No information will be shared or distributed without client or parent consent. Initial here _____

The information above is meant to ensure that the expectations between Cobblestone Therapy Group and our clients are aligned.

Client or Parent/ Guardian (Print Name) _____

Child's Name: _____

*Signature*_____

*Date*_____

Cobblestone Therapy Group

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Roswell, GA 30075

Phone: 770-998-9599
Fax: 770-645-1313

CREDIT/DEBIT CARD AUTHORIZATION (MANDATORY)

I authorize Cobblestone Therapy Group to maintain my credit/debit card on file. I understand that the card will only be used if:

(a) My child's account has been **delinquent for more than 60 days** and I have not made any effort to make payment arrangements

(b) My child's **appointment is cancelled with less than 24 hours notice** (late cancellation) or a **"no show"** occurs for a scheduled appointment.
The fee for late cancellation and/or no show is $40 per 30 minute session, $80 per 60 minute session.

(c) My child's appointment is seen for therapy off-site and I authorize Cobblestone to charge applicable co-pays or co-insurance.

(d) My child's appointment is on-site and I prefer the office to charge my co-pays each visit.

_____ _____
Cardholder Signature Date

Patient's Name:		
Cardholder's Name:		Phone
Cardholder's Address:		
City:	State:	Zip:
___VISA ____ MASTERCARD		
Credit Card Number:	Exp:	CVV: