Launch Registration Form

Child's Full Name:_____ Preferred Name:_____

DOB:_____ Age:_____ Sex: ☐ M ☐ F SS#_____-_____-_____

Address:_____Apt/Lot:_____

City:_____ State: _____ Zip:_____

Mother/Guardian Name: _____

Are you the legal guardian? ☐ YES ☐ NO Are you authorized to make medical decisions for the patient? ☐ YES ☐ NO

Daytime Phone:_____ Cell Phone:_____

Father/Guardian Name: _____

Are you the legal guardian? ☐ YES ☐ NO Are you authorized to make medical decisions for the patient? ☐ YES ☐ NO

Daytime Phone:_____ Cell Phone:_____

Email Address:_____

Doctor's Name:_____ Doctor's Phone:_____

INSURANCE/BILLING INFORMATION –***We will need to copy all insurance cards & a photo ID.***

Primary Insurance:_____

Subscriber's Name:_____ DOB:_____ SS#:_____-_____-_____

Member/Subscriber ID:_____ Group #:_____

Relationship to Subscriber: ☐ SELF ☐ CHILD ☐ OTHER Employer: _____

Secondary Insurance (if applicable): _____

Subscriber's Name:_____ DOB:_____ SS#:_____-_____-_____

Member/Subscriber ID:_____ Group #:_____

Relationship to Subscriber: ☐ SELF ☐ CHILD ☐ OTHER Employer: _____

IN CASE OF EMERGENCY

Name: _____Phone:_____ Relationship to child:_____
Name: _____Phone:_____ Relationship to child:_____

******ALLERGIES/DIETARY RESTRICTIONS******

Allergen: _____ Reaction:_____

Allergen: _____ Reaction: _____

Dietary restrictions: _____

IDENTIFYING AND FAMILY INFORMATION

Child lives with (check one):

☐ Birth Parents ☐ One Parent ☐ Parent/Step-Parent ☐ Foster Parents

☐ Adoptive Parents ☐ Grandparents ☐ Other _____

Other children in the family

Name	Age	Sex	Grade	Developmental Delay

BIRTH HISTORY

Was there anything unusual about the pregnancy and/or birth? ☐ YES ☐ NO

IF YES, Please explain:

_____

_____

Age of mother at child's birth:_____

Was the mother sick during the pregnancy? ☐ YES ☐ NO

How many months/weeks was the pregnancy?_____

How long did the child stay in the hospital after birth?_____

Surgical History:

Type of Surgery:_____ Date:_____

Doctor's Name:_____

Type of Surgery:_____ Date:_____

Doctor's Name:_____

Other Serious Injury:_____ Date:_____

MEDICAL HISTORY

Does your child have a formal diagnosis? YES ☐ NO ☐ Diagnosis:_____

Who made the Diagnosis?_____ Date diagnosis was made:_____

Please list all medications (prescribed/over the counter/vitamin) your child takes regularly:

Name	Dose	Prescribing Doctor

Has your child had problems with any of the following: Please check all that apply

☐ Allergies	☐ Breathing	☐ Chicken Pox	☐ Cleft Palate
☐ Encephalitis	☐ Ear Infections	☐ Flu	☐ Head Injury
☐ High Fevers	☐ Measles	☐ Mumps	☐ Scarlet Fever
☐ Staph Infection	☐ Seizures	☐ Sinusitis	☐ Sleeping
☐ Tongue Clip	☐ Tonsillitis	☐ Finger Sucking	

VISION/HEARING HISTORY

Do you have any concerns regarding your child's vision? ☐ YES ☐ NO

Date of last Vision test:_____

Results:_____

Doctor:_____

Does your child wear eyeglasses or contacts? ☐ YES ☐ NO

Do you have any concerns regarding your child's hearing? ☐ YES ☐ NO

Date of last hearing test:_____

Results:_____Doctor:_____

Does your child have a hearing aid or cochlear implant? ☐ YES ☐ NO

EDUCATIONAL HISTORY

School:_____ Grade:_____ Teacher's name:_____

Does your child receive therapy in school? ☐ YES ☐ NO

School Therapist name:_____

Please indicate your child's educational setting and services. <u>Circle</u> all that apply. Where applicable, indicate <u>how many times per week and duration of sessions</u>.

Regular Education

Fully Mainstreamed

Partially Mainstreamed (for:_____)

Self Contained Class (type:_____)

Resource Room (for:_____)

Specialized School (name:_____)

Physical Therapy_____a week

1:1 aide_____a week

ABA_____a week

Occupation Therapy_____a week

Social Skills_____a week

Speech-Language Therapy_____a week

DEVELOPMENTAL HISTORY

Please indicate whether or not your child achieved the following milestones within the given time. If not, please indicate when your child achieved the milestone.

Crawled by 9mos ☐ YES ☐ NO____

Sat up by 8mos ☐ YES ☐ NO____

Stood by 12mos ☐ YES ☐ NO____

Walked by 14mos ☐ YES ☐ NO____

Dressed self by 5yrs ☐ YES ☐ NO____

Combined words by 2yrs ☐ YES ☐ NO____

Toilet trained by 2yrs ☐ YES ☐ NO____

Single words by 12mos ☐ YES ☐ NO____

Fed self with a utensil by 18mos ☐ YES ☐ NO___

Rolled stomach to back by 5mo ☐ YES ☐ NO____

Rolled back to stomach by 8 mos ☐ YES ☐ NO____

Behavioral Characteristics (check all that apply):

☐ Cooperative ☐ Restless ☐ Attentive ☐ Poor eye contact ☐ Frustrated

☐ Destructive ☐ Aggressive ☐ Easily distracted ☐ Tries new things ☐ Stubborn

☐ Impulsive ☐ Withdrawn ☐ Plays alone ☐ Self-abusive

Your child's favorite toys:_____

Please describe your child's social skills:_____

Check all that apply:

☐ Prefers to play alone

☐ Plays well with other children of the same age

☐ Excessive shyness / clinging to caregiver

☐ Limited initiation of social contact

☐ Difficulty maintaining social interaction

☐ Difficulty showing emotion

☐ Social anxiety

Patient Name: _____ DOB: _____

Caregiver Agreement

Caregivers play a vital role in the success of our patients in therapy. The following are expectations as you proceed in helping your child reach optimum outcomes in therapy. Please initial each point to indicate understanding.

___ The patient will attend 80% of visits.

___ Caregivers will call at least 24 hours before the scheduled appointment time if they need to cancel or change the appointment.

___ The parent should cancel if the patient has had diarrhea, thrown-up, or has had a fever over 100 degrees within 24-hours of their scheduled appointment time.

___ If you cancel/no show the day of the appointment without a doctors excuse, a 25.00 charge will be added to your account.

___ The caregiver will complete home program activities as directed by the treating therapist.

___ The caregiver agrees to student clinician and volunteer participation in the therapeutic procedures as part of patient care under the direct supervision of the treating therapist.

___ Two or more consecutive no show visits may result in loss of ongoing appointment time.

Failure to comply with these may result in the patient being returned to the wait list or losing the preferred appointment time.

We at Launch appreciate your collaboration between caregivers and therapists and want to ensure our patients achieve maximum results.

*Your patient has attended ____ percent of visits over the last 3 months.

_____ _____

Caregiver Signature Date

Notice of Privacy Practices LAUNCH will ask you to sign an Acknowledgement that you have received with this Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPAA Privacy Regulations, how LAUNCH may use and disclose your protected health information to carry out treatment, payment or health care operations and for other specific purposes that are permitted or required by law. The Notice also describes your rights and Launch's duties with respect to protected health information about you. If you have any questions about this Notice or about our privacy practices, please contact Chantelle Varnado at (225)380-1894.

Treatment, Payment and Health Care Operations LAUNCH is a non-profit preschool and therapy center, which offers a variety of services for individuals with disabilities and for their families. These services include occupational, physical, and speech-language therapy, as well as a multi-disciplinary early intervention program and other programs to serve the patients and their families. Therapy is provided both individually and in groups, primarily at our therapy clinic, with some community-based therapy sessions. We may use or disclose health care information to receive payment for services from state agencies, parish agencies, insurance companies or others who pay costs of some of all of your health care. We will use your health care information to carry out health care operations. This includes but is not limited to: scheduling appointments, greeting and announcing on arrival, assisting your therapist/therapy team during the child's appointment, arranging referrals, and maintaining records. We may use your health care information to evaluate the quality and competence of our therapists and other health care staff. All employees, staff, volunteers, contractors, and other personnel of LAUNCH must abide by these policies. Organizations affiliated with LAUNCH work together in an integrated setting for education and training purposes will also follow these policies. HIPAA permits a single Notice to describe how your health care information will be protected.

Notification and Disclosures with Family or Business Associates Using their judgment as health care professionals, our staff may disclose your child's health care information to a personal/legal representative (one who has valid Power of Attorney, a conservator or a guardian), another person responsible for care. We form contracts with entities known as Business Associates to whom we perform services for. We may disclose health care information in the interest of handling your child's case as it relates to meetings and reporting. We require all Business Associates to appropriately safeguard the health care information.

Other Required or Permitted Disclosures

We may disclose your health care information to the following entities and/or under given circumstances:

- collaboration with other professionals within the LAUNCH organization working directly with your child may involve disclosing health information to provide optimal services.

- to public health authorities for the purpose related to; preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting disease of infection exposure;

- to health agencies during the course of audits, investigations, inspections, licensure and other proceedings;

- in the course of any administrative or judicial proceedings;

- to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes;

- to researchers conducting research that has been approved by an Institutional Review Board;

- to contact the patient for the purpose of fundraising;

- to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public;

- to contact you as a reminder that you have an appointment for treatment.

- to provide you with information about other health-related benefits and services that may be of interest to you.

Authorized Use and Disclose of your Health Care Information We will obtain written authorization before using or disclosing health care information about your child for purposes other than those listed above or otherwise permitted or required by law. You may revoke an authorization in writing at any time.

Your Health Care Information Rights You have the right to request restrictions on certain uses and disclosures of your health care information. However, LAUNCH is not required to agree to the restriction that you requested. Upon written request, you have the right to receive your health care information through a reasonable alternative means or at an alternative location. You have the right to request or inspect a copy of your child's health care information. To receive a copy of your child's health care information, you must send a written request to the Executive Director. You have the right to inspect and request an amendment to your child's health information. We may deny your request if your request is regarding information that was not created by us, is not part of the information recorded by LAUNCH, or is accurate and complete. You have the right to request that we communicate with you about protected information in a certain way or at a certain location. You have a right to request an accounting of disclosures made for the purposes outlined by HIPPA. You have the right to a paper copy of this notice.

Our Responsibilities It is our responsibility to ensure your health information is kept private, provide notice of our legal duties and privacy practices, notify you in the event that we discover a breach of protected information, and follow the terms of this notice.

Changes to this Notice of Privacy Practices LAUNCH reserves the right to amend this Notice of Privacy practices at any time in the future and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendments. Until such amendments are made, LAUNCH is required by law to comply with this Notice.

For Information or to Report a Problem If you have questions or would like additional information about our privacy practices, you may contact the Executive Director at LAUNCH. Complaints about how LAUNCH handles your health care information should be directed to LAUNCH's Executive Director. If you believe your rights have been violated, you can file a complaint with the Secretary of Health and Human Services or go online to http://www/hhs.gov/ocr/regmail.html for a list of offices. *Effective Date 8/3/15.*

I acknowledge receipt of Privacy Practices Policy: _____ _____

Parent/Guardian Signature **Date**

LAUNCH

RELEASE FOR VIDEO AND PHOTOGRAPHY

I,_____(patient's guardian), give permission for _____(patient) to be videotaped and/or photographed by the staff of, or qualified professionals given permission by Launch Therapeutic Preschool and Therapy Services for the following purposes:

Check all that apply:

- ☐ Public relations media and social media for the launch and affiliated organizations
- ☐ Training graduate and undergraduate students
- ☐ Marketing
- ☐ Research publications and presentations

You WILL be notified when/if a photograph/video is used.

_____ _____

Signature of Parent/Guardian Date

LAUNCH

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of birth_____

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____(individual seeking the information).

2. This authorization for release of information covers the period of healthcare from:

A. ☐ _____ to _____. OR B. ☐ all past, present, and future periods.

3. Extent of Authorization

A. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

B. □ I authorize the release of my complete health record with the except:
□ Mental health records □ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment □ Other (please specify):
_____

4. This authorization shall be in force and effective until _____ (date or event), at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of Legal Guardian

_____ _____
Printed name of legal guardian and his or her relationship to patient Date