



Welcome to Canyon Kids!

Canyon Kids offers a full range of Pediatric Occupational Therapy Services including comprehensive OT evaluations, consultations, individual OT sessions, and group OT sessions. Your child is scheduled for a 30-minute, free screening with one of our professional Occupational Therapists.

The brief screening will include about 15 minutes of testing with your child to observe Fine Motor, Gross Motor, and Sensory Motor Skills. The additional 15 minutes of the screening time will include a consultation with you. Based on the screening, you and the OT may decide that further information or intervention is needed. Please be reminded that this is only a screening and not a full OT evaluation.



Please complete all the information requested below. **The information requested is: general contact information and your signature to confirm your agreement with the clinic's policies. Copies of the policies are included for you to keep for your records. Please bring the completed forms to your child's screening session.**

The Canyon Kids clinic is conveniently located in downtown Bethesda. If driving, there is meter parking on Rugby Avenue and the surrounding streets (quarters accepted). There is a metered, public parking garage to the right of the building when facing our building. Do not park in the garage attached to the left of our building's front door.

The Metro's red line has two stops near our clinic: Bethesda and Medical Center. Also, the Bethesda Circulator is a free bus with a convenient route through Bethesda. Please consult our website for more details at www.canyonkids.com.



Our clinic has a waiting area where the therapist will meet you, or an approved caregiver, at the beginning of your child's screening session. We welcome you to watch your child during the screening.

Thank you again for choosing Canyon Kids and Welcome! We are looking forward to working with your child and family.

Sincerely,

A handwritten signature in blue ink that reads "Christine T. Sproat MA, OTR/L".

Christine T. Sproat MA, OTR/L; Director



GENERAL CONTACT INFORMATION

Today's Date _____

Referred By _____

Name of Patient _____

Date of Birth _____

Gender Male / Female (circle one)

Diagnosis _____

Child's Home Telephone _____

Child's Home Address _____

Parent1 Name _____ Home Phone _____

Parent1 Cell Phone _____ Parent1 Work Phone _____

Parent1 Email _____

Parent2 Name _____ Home Phone _____

Parent2 Cell Phone _____ Parent2 Work Phone _____

Parent2 Email _____

Pediatrician _____ Pediatrician Phone _____

Siblings Names and Ages _____

Precautions/Medications _____

Emergency Contact _____ Relationship to Child _____

Emergency Phone1 _____ Emergency Phone2 _____

Please Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our clinic.

Name of Parent/Legal Guardian _____

Signature _____ Date _____



AGREEMENT AND WAIVER FOR PARTICIPATION IN ONSITE THERAPY

I (print parent/guardian name) _____ the parent or guardian of (patient's name) _____ (thereafter referred to as "my child") give permission for my child to participate in screening sessions at Canyon Kids Pediatric Occupational Therapy Services.

I hereby release Canyon Kids, its principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Canyon Kids in connection with this program from any and all claims which I or my child may have arising from, resulting from, or in connection with my child's participation therapy, including, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play equipment during the program. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Canyon Kids, its principal owners, therapists, employees, representatives, and all other individuals or organizations acting on behalf of Canyon Kids, in connection with this program from all liability as herein described.

Name of Parent/Legal Guardian _____

Signature _____ Date _____



NOTICE OF PATIENT PRIVACY PRACTICES

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your child's personal health information may be used by Canyon Kids Pediatric Occupational Therapy Services for treatment, obtaining payment, during an audit, in emergencies, or when required by law. The child's parent/guardian will be asked for written authorization to use the child's personal medical information for any other reason than those listed above. You have the right to review your child's personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment, or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment, and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of your child's health privacy to the US Department of Health and Human Services.

For further questions, you may contact the Compliance Officer

Rachel Griffin
4833 Rugby Avenue
Suite 101
Bethesda, MD 20814

PATIENT INFORMATION CONSENT FORM

I have read and understand this practice's **Notice of Patient Privacy Practices**. I understand that the company may use or disclose my child's personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my child's personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the Company. I also understand that the Company will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my child's personal health information for purposes as noted in the Company's **Notice of Patient Privacy Practices**. In doing so, I hereby release Canyon Kids from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

Patient's Name _____

Name of Parent/Legal Guardian _____

Signature _____ Date _____

4833 Rugby Avenue ❖ Suite 101 ❖ Bethesda, Maryland 20814
Phone: 301-523 - 0902 ❖ Fax: 301-913-2939 ❖ www.canyonkids.com



PLEASE KEEP THIS AGREEMENT FOR YOUR RECORDS (4 pages total)

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HIPAA AGREEMENT FOR COVERED BUSINESS ENTITY

Name of Covered Entity	Canyon Kids Pediatric Occupational Therapy Services
Names of Business Associates	Christine Sproat MA, OTR/L Shannon Elie OTR/L Allison Martin MS, OTR/L Kerri Sawyer MOTR/L Erica Bruscke MS, OTR/L Rachel Griffin Candace Tucker

A. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

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Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule

Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

1. Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).



Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

B. OBLIGATIONS OF COVERED ENTITY

1. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

2. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate

3. Term and Termination

Term: The Term of this Agreement shall be effective as of January 1, 2013 and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

Termination for Cause: Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement

Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or



If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

Effect of Termination: Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon [Insert negotiated terms] that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

C. MISCELLANEOUS

Regulatory References: A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

Amendment: The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

Survival: The respective rights and obligations of Business Associate under Section [Insert Section Number Related to "Effect of Termination"] of this Agreement shall survive the termination of this Agreement.

Interpretation: Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.