Mary Subra, OTR/L

Greetings to future participants;

In order to qualify for therapy we must have the following;

A Dr's order for Occupational therapy to evaluate and treat

The order should be good for a 6 month period of time.

Also I will need you to complete the following paperwork so that I can best serve you and your child.

If you have any questions after receiving this paperwork please call me at (770) 601-5044

Mary Subra, OTR/L

To: All clients and Parents of Clients of Mary Subra, OTR/L

The Federal Government has adopted new regulations concerning how Protected Health Information (PHI) may be used, and how health related facilities handle PHI. Protected Health Information or PHI can be defined as any medical information about a person with the person's name or other identifying information attached. As part of the new regulations, I, Mary Subra, must give you a copy of our Official Notice of Privacy Practices. Enclosed you will find your copy of this notice. You will also find a copy of the Privacy Consent Form. By signing the Consent Form you are acknowledging that you received the Notice of Privacy Practices and that you agree to allow Mary Subra to use the PHI in the ways outlined in the Privacy Notice.

The Notice of Privacy Practices is a legal document. As a legal document the notice may be difficult to understand. The notice states that I, Mary Subra, may use PHI for routine uses like billing, providing services to clients, and to communicate with other health care providers who are working with you or your child without getting special permission from you. The notice states that for all non-routine uses, I, Mary Subra, must get specific permission from you to use the PHI. The Notice also allows Mary Subra to use PHI that has all identifying information removed without getting your permission. This is a very brief summary of the Notice. This summary does not include everything that is covered in the Notice of Privacy Practices and you should read the entire notice.

Please read the notice and return the signed Consent Form to Mary Subra, or mail to:

Mary Subra, OTR/L
191 Pittypat Place
McDonough, Georgia 30253

If you have questions or concerns about the Notice of Privacy Practices please call Mary Subra at (770) 601-5044

Thank you for allowing me to meet all of your therapy needs.

Sincerely yours,

Mary Subra OTR/L

Mary Subra, OTR/L

Mary Subra, OTR/L

NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this notice, please contact Mary Subra, OTR/L at 770-601-5044

WHO WILL FOLLOW THIS NOTICE:

This notice describes the privacy practices/procedures of Mary Subra, OTR/L and those of:

All departments and units of Mary Subra's practice.

Any volunteer working with Mary Subra, OTR/L.

Any employees, staff, students/interns and other practice personnel of Mary Subra, OTR/L.

MY PLEDGE REGARDING YOUR HEALTH INFORMATION:

I understand that information about you or your child and your health is personal. I am committed to protecting your health information. I create a record of the care and services you receive at my practice, as well as records regarding payment for those services. I need these records to provide you with quality therapy and to comply with certain legal requirements. This notice applies to all of the records of your care generated by me and/or staff. This notice also applies to information I receive from doctors, other therapists, educators or other people, or practices helping me to provide you with quality therapy services.

This notice will tell you about the ways in which I may use and disclose medical information about you or your child. Here also is a description of your rights, and certain obligations we have regarding the use and disclosure of medical information.

I am required by law to:

Make sure that medical information that identifies you is kept private.

Give you this notice of our legal duties and privacy practices with respect to medical information about you or your child and follow the terms of the notice that are currently in effect.

SPECIAL SITUATIONS

Workers' Compensation: If applicable, I may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risk: I may disclose medical information about you or your child for public health activities. These activities generally include the following:

To prevent or control disease, injury or disability;

To report problems with products;

To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

To notify the appropriate government authority if I believe you or your child have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: I may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, I may disclose medical information about you or your child in response to a court or administrative order. I may also disclose medical information about you or your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested

Law Enforcement: I may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant summons or similar process; and, about criminal conduct within the practice.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD

You have the following rights regarding medical information I maintain about you or your child:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your or your child's care. Usually, this includes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you or your child, you must submit your request in writing to Mary Subra, OTR/L. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other supplies associated with your request.

I may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed if the denial is made for certain reasons. Another licensed health care professional chosen by me, Mary Subra, OTR/L, will review your request and the denial. The person conducting the review will not be the person who denied your request. I will comply with the outcome of the review.

Right to Amend (Change): If you feel that medical information I have about you or your child is incorrect or incomplete, you may ask to amend (correct) the information. You have the right to request an amendment for as long as the information is kept by or for Mary Subra, OTR/L.

To request an amendment, your request must be made in writing and submitted to Mary Subra, OTR/L. You must also give a reason as to why you are making your request.

I may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition I may deny the request if you ask us to amend information that:

> Was not created by Mary Subra, OTR/L, unless the person or entity that created the information is no longer available to make the amendment.
>
> Is not part of the medical information kept by or for MARY Subra, OTR/L.
>
> Is not part of the information which you would be permitted to inspect and copy or, is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "Accounting of Disclosures." This is a list of certain disclosures we made of medical information about you or your child.

To request this list of Accounting of Disclosures, you must submit your request in writing to Mary Subra, OTR/L. Your request must state a time period, which may not start more than six years in the past and may not include dates before April 14, 2003.Your request should indicate in what form you want the list (i.e. on paper or faxed). The first list you request within a 12-month period will be free. For additional lists, I may charge you for the costs of providing the list. I will notify you of the cost and you may choose to withdraw/modify your request at that time before costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information I use or disclose about you or your child for treatment, payment, or health care operations purposes. You may also request a limit on the medical information I disclose about you or your child to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that I not use or disclose information to your grandmother, or that I not use your information in any quality assurance activities.

I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Mary Subra, OTR/L. In your request you must tell me (1) what information you want limited; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example disclosures to your grandmother.

Right to Request Confidential Communications: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at home or by mail.

To request confidential communications, you must make your request in writing to Mary Subra, OTR/L. I will not ask you the reason for your request. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To obtain a paper copy of this notice contact Mary Subra, OTR/L at 770-601-5044.

CHANGES TO THIS NOTICE

I reserve the right to change this notice. I reserve the right to make the revised or changed notice effective for medical information I already have about you or your child as well as any information we receive in the future. I will always have a copy of the current notice on my persons. The notice will be in effect the date you sign the "NOTICE OF PRIVACY PRACTICES CONSENT FORM".

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me, Mary Subra, OTR/L directly, or with the Secretary of the Department of Health and Human Services. To file a complaint contact Mary Subra, OTR/L at 770-601-5044. All complaints must be submitted in writing.

You will not be penalized in any way for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide me permission to use or disclose medical information about you or your child, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose medical information about you or your child for the reasons covered by your written authorization. You understand that I am unable to take back any disclosures I have already made with your permission, and that I am required to retain all records of the care that I provided to you.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU OR YOUR CHILD

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am allowed to use and disclose information will fall within one of the categories.

For Treatment: I may use health information about you or your child to provide you with therapy treatment or services. I may disclose medical information about you or your child to doctors, other therapists, student therapists/interns, nurses, or other people who are involved in taking care of you or your child. I also may share medical information about you or your child in order to coordinate the different things you need, such as wheelchairs or orthotics (braces).

For Payment: I may use and disclose health information about you or your child so that the treatment and services you receive by me may be billed and that payment may be collected from you, an insurance company or other third party. For example, I may need to give your health plan information about services that you received through our practice so your health plan will pay me or reimburse you for the services. I may also tell your health plan about equipment or treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the equipment or treatment.

For Health Care Operations: I may use and disclose medical information about you or your child for health care operations. These uses and disclosures are necessary to run my practice and to make sure that all patients receive quality care. For example, I may use medical information to review treatment and services and to evaluate the performance of any staff in caring for you. I may also combine medical information about many of our patients to decide what additional services my practice should offer, what services are not needed, and whether certain new treatments are effective. I may also disclose information to doctors, nurses, student therapists and other personnel for review and learning purposes. I may also combine the medical information I have with medical information from other facilities to compare how I am doing and see where I can make improvements in the care and services I offer. I may remove information that identifies you from this set of medical information so others may use it to study health care delivery without learning who the specific patients are.

Treatment Alternatives: I may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services: I may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: I may release medical information about you, or your child to a friend or family member who is involved in your or your child's medical care. I may also give information to someone who helps pay for your care. I may also tell your family or authorized friend of your or your child's condition.

As Required By Law: I will disclose medical information about you or your child when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: I may use and disclose medical information about you or your child when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Mary Subra, OTR/L

Privacy Consent Form
For Use and Disclosure of Protected Health Information

This Notice of Privacy Practices provides information about how I may use and disclose protected health information about you or your child. You have the right to review this Notice before signing this consent. As provided in the Notice, the terms of the Notice may change. If changes to the Notice occur, you may obtain a revised copy by requesting a copy in writing to:

Mary Subra, OTR/L
191 Pittypat Place
McDonough, Georgia 30253

Phone (770) 601-5044
Fax (678) 432-2834

You have the right to request that I restrict how your protected health information is used or disclosed for treatment, payment, or health care operations. Please note that I am not required to agree to such a restriction. If I do agree, we are bound by that agreement.

By signing this form, you consent to Mary Subra's use and disclosure of protected health information about you or your child for treatment, payment, and health care operations. You do not have to sign this consent and if you sign this consent, you have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

By signing this form, you also state that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name: _____ _____
(Please Print) **Signature of Parent/Guardian**

Date: _____

MARY ANN SUBRA, OTR/L

191 Pittypat Place

McDonough, Georgia 30253

770-601-5044 678-432-2834 fax

Date _____ Patient Full Name _____

DOB _____ M ___ F ___

Address *(street)* _____ *(apt./lot)* _____

City _____ State _____ Zip code _____

Phone *(home)* _____ Work _____ Cell _____

In case of emergency notify _____ Phone _____

Relationship to patient _____

Primary Care Physician _____ Phone _____ Fax _____

Address *(Street)* _____

City _____ State _____ Zip code _____

Does patient have a Specialty doctor (s)? Y ___ N ___ If yes, please list the information for your specialty doctor.

Name _____ Phone _____ Fax _____

Address *(Street)* _____

City _____ State _____ Zip Code _____

If an accident, where and when did it happen? _____

Skilled diagnosis _____ ICD-9 Code (s) _____

Payment

(Check all payment sources available).

BCW ___ Medicaid/CMO___ Worker's Compensation___ Group Health Plan___ Individual Policy___ Litigation___

Please fill in below the information associated with the payment source that is checked above.

Responsible party

Name of insurance holder _____ Date of birth _____

Address *(street)* _____ *(apt./lot)* _____

City _____ State _____ Zip code _____

Phone *(home)* _____ Work _____ Cell _____

Employer _____ Phone _____

Insurance company _____ Plan type/Name _____

Address *(Street)* _____ *(suite)* _____

City _____ State _____ Zip code _____

ID number _____ Group number _____ M_____ F_____

Is there any other Health Benefit Plan? Y___ N___

If your answer is yes, please let us know.

Assignment of Benefits

My insurer (Medicaid, CMO's, insurance company, attorney, etc.) is hereby requested to pay directly to Mary Ann Subra, OTR/L, any monies due on my behalf. I understand that in Medicaid assigned benefits or Champus participation claims, Mary Ann Subra, OTR/L agrees to accept the payment determination of the carrier as full payment and I am only responsible for the deductible, coinsurance, out of network costs and non-covered services on my claim. I agree to pay Mary Ann Subra, the deductible, coinsurance, out of network costs and non-covered services on my claim as soon as notified. I understand the I am responsible for all the fees not covered by insurance, Medicaid, CMO's, etc., if it is determined that such coverage does not exist or has been terminated for any reason..

Name *(print)* _____ Signature _____

Date _____

MARY ANN SUBRA, OTR/L

191 Pittypat Place

McDonough, Georgia 30253

770-601-5044 678-432-2834 fax

Patient Authorization to Treat

I certify that I have been instructed in the treatment and or procedure for myself/child and the expected potential of treatment. I agree with and accept the plan of care as outlined by the therapist.

Patient/Parent/Guardian signature_____ Date_____

Responsible Party ***(print)*** _____

MARY ANN SUBRA, OTR/L

191 Pittypat Place

McDonough, Georgia 30253

770-601-5044 678-432-2834 fax

Medical History

Name _____ Date of birth _____ M____ F____

Name of current primary caretaker _____

Date, name, and address of last check-up with the present Primary Care Physician/Pediatrician? Date _____

Name (*location)* _____ Phone _____ Fax _____

Address *(Street)* _____ Suite _____

City _____ State _____ Zip code _____

Have you/child ever been to a health department? Y _____ N _____ Date _____

What County? _____ Phone _____ Fax _____

Address *(Street)* _____ Suite _____

City _____ State _____ Zip Code _____

Have you/child ever seen a dentist or orthodontist? Y _____ N _____ Date _____

Name _____ Phone _____ Fax _____

Address *(Street)* _____ Suite _____

City _____ State _____ Zip Code_____

Have you/child ever been hospitalized? Y _____ N _____ If yes, list dates and reasons.

Date _____ Reason _____

Date _____ Reason _____

Are you/child currently taking any medications? Y _____ N _____

If yes, please list present medications. _____

_____

List any concerns regarding your/child's health. _____

_____

Do you/child suffer from seizures? Y _____ N _____

Please check if you/child have contracted any of the following:

___ chicken pox
___ mumps
___ measles (7 day or red measles)
___ whopping cough
___ frequent chest infections
___ pneumonia
___ German measles
___ Other_____

Date of your/child's last vision or hearing screening? _____

Do you/child ever have any of the following problems? Check all that apply.

___high blood pressure
___kidney infection
___low blood (anemia)
___bleeding
___swelling
___tuberculosis
___lung disease/ difficulty breathing
___ ear infections
___ heart disease/problems
___other _____

Are you/child currently seeing other therapist? Y _____ N _____ If yes, please list below (all past and present) therapist(s) name, the type of therapy and the therapist(s) phone number.

_____

_____

Thank you so much for taking the time to fill out this paperwork! This enables me to give you/child the best care possible. Please feel free to ask any questions or state any concerns you may have.

Authorization to Release Information

I hereby authorize

___ _____

(OTHER)

or _____

_____

_____

to release all valuable educational, psychological, medical (other)_____

information on myself/child Name _____ Date of birth _____

in order to determine the most appropriate treatment program.

Records are to be released to

___ **Mary Ann Subra, OTR/L** _____

191 Pittypat Place *(OTHER)*

McDonough, GA 30253 *or* _____

_____

_____

I understand that the information contained in my or my child's medical/school records is confidential and will be released only upon my signature.

Signature of patient/parent/guardian _____ Date _____