

Horn and Associates in Rehabilitation, PLLC

Parent Questionnaire

Today's Date _____

Identifying Information

Child's Name _____ Date of Birth _____ Sex _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone(s) _____

Email Address(es) _____

Please * preferred method of communication above (home or cell phone, email)

1st Parent/Guardian Name _____ Date of Birth _____ SSN _____

Address (if different from above) _____

Occupation / Place of Work _____

2nd Parent/Guardian Name _____ Date of Birth _____ SSN _____

Address (if different from above) _____

Occupation / Place of Work _____

Billing Preference (please circle)

Insurance

Private Pay

Other _____

Responsible Party _____

Reason for referral / Concerns

Who referred child for services? _____

Physician Name _____

Physician Number and Address _____

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Has the child received therapy services in the past? _____

If so, list type of service(s) and length of service(s) _____

Child's school and current grade / daycare _____

Developmental and Medical History

Was the child born full term? _____ If premature, how many weeks? _____

Please describe pregnancy (any infections or illnesses, stress, complications, medications, etc.)

Please describe labor and delivery (vaginal, Cesarean section, induction, complications, length of labor, etc.)

Please describe any significant neonatal issues (NICU stay, need for oxygen and/or fetal monitor, congenital abnormalities, need for surgery, difficulty with feeding, jaundice, colic, etc.)

Please list history of significant illnesses, surgeries, hospitalizations, etc., such as frequent ear infections, strep throat, gastrointestinal issues, seizures, asthma, allergies, need for ear tube placement, tonsillectomy, etc.

Please list any specialists your child has seen, along with when seen and reason for visit.

Has your child had a hearing evaluation? Please list findings _____

Has your child had a vision screening and/or wear glasses? _____

Please list any medications your child takes _____

Please list any diagnoses your child may have received

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To the best of your knowledge, at what age did your child:

Roll over _____ Sit Independently _____ Crawl _____
Stand Alone _____ Walk _____ Go Up and Down Stairs _____
Finger Feed _____ Transition to Solid Foods _____ Transition from Bottle to Cup _____
Use Utensils to Feed Self _____ Toilet Train _____ Sleep through the Night _____
Say First Word _____ Put Two Words Together _____ Follow Simple Directions _____

Family and Social History

Please list individuals (with their ages and relationship to child) that live in the same home with the child

Do any family members or those living with child have a history of developmental concerns or delays? If so, please list relationship and concern

What is the primary language spoken in the home? _____

Are there any other languages spoken in the home? If so, please list _____

Does your child have interaction with same-age peers or other children? _____

Does your child interact well with other children? _____

What is your child's favorite activities/toys? _____

Please describe your child's personality and strengths _____

HORN AND ASSOCIATES IN REHABILITATION, PLLC



2412 Greatstone Point
Lexington, Kentucky 40504
Phone (859) 224-4081

4127 Todds Road
Lexington, KY 40509
Fax (859) 224-4082

www.horntherapy.com

2023 Release of Information / Consent to Treatment

Client Name: _____ Date of Birth: _____

I hereby authorize Horn and Associates in Rehabilitation, PLLC, to **release** any information including the diagnosis, records, evaluation rendered to me, and any other information to establish and maintain good care.

Initials are required to disclose privileged information: _____ Psychological Records _____ Social Service Records

This information may be released to and from (2-way release):

Insurance: **YES** **NO** _____

Physician: **YES** _____ **NO** _____

Physician Name: _____

Physical Address: _____

Physician Phone Number: _____

List additional people you choose to have access to this information (e.g., other family members, caregivers, health care professionals, teachers/schools)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, or custodial parent/legal guardian, give permission for **Horn and Associates in Rehabilitation, PLLC**, to administer and interpret assessments and/or testing measurements, and/or initiate therapy, and/or seek emergency medical treatment if required.

CONDITIONS

- The patient or legal parent/guardian agrees to authorize the above named individuals/organization to access her/her confidential health information only for the purpose listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- The patient or legal parent/guardian agrees that any sharing of confidential health information with individuals/organization listed above may be mailed, faxed, electronically sent and/or hand delivered.
- The patient or legal parent/guardian is voluntarily signing this authorization.
- The patient or legal guardian/parent reserves the right to refuse to sign this authorization.
- The patient or legal guardian/parent reserves the right to revoke this authorization at any time. The revocation must be in writing.
- This authorization will be maintained by Horn and Associates in Rehabilitation, PLLC, for a period of twelve (12) months.

I agree to the supervised participation of health care learners in my care (e.g., resident students, therapy students, graduate students, other clinical students, etc.). I understand my patient records will be held in strict confidentiality and will not be discussed outside the office. _____ **(Initials)**

Through my execution of this authorization, I represent that I have legal authority to authorize the foregoing and agree to hold Horn and Associates in Rehabilitation, PLLC, harmless and indemnify from and against any and all losses and/or claims they may suffer by reasons of breach of the foregoing representation.

I have read, reviewed and agree with: Horn and Associates in Rehabilitation, PLLC *Notice of Privacy Practices and Disclosure Against Surprise Billing*. A copy of these will be given upon request.

Printed Name: _____

Client or Custodial Parent/Legal Guardian Signature: _____ Date: _____

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2023 CONSENT TO TREAT USING TELEHEALTH

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that there are potential risks involving technology, including but not limited to: Internet interruptions and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my user name and password and not share these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if it is felt that this type of service delivery does not benefit my needs.

I have read and understand the information provided above regarding telehealth or teletherapy, have discussed it with my health care provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth or teletherapy in my care."

Client Name: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

Emergency Contact (Name and Phone Number): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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2023 ST/OT/PT OFFICE TERMS AND CONDITIONS

Patient Name: _____ Date of Birth: _____

Thank you for choosing us for your speech/language, occupational, and/or physical therapy needs. We are committed to providing you with quality and affordable services. Our office policies are outlined below. Please read, ask us any questions, initial and sign in the space provided. A copy will be provided to you upon request.

FINANCIAL POLICY

We are happy to send claims to insurance but please keep in mind professional services are rendered and charged to you or the patient and not to the insurance company.

Proof of Insurance: All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license/government-issued photographic identification and current valid proof of insurance. You are responsible to know your benefits. We will collect estimated out of pocket fees on the day of therapy, which includes deductible, copays and/or co-insurance. Our office accepts cash, checks, MasterCard, Visa and Discover. Families are responsible for keeping track of the number of visits, or when and what type of authorization/precertification is necessary. The number of visits and payment of all claims is your responsibility, although we do try to track them as well. Please remember that precertification and/or authorization is no guarantee of payment from your insurance company. Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. We are happy to help you with additional information your insurance company may need to assist in claim payment; however, our office will not enter into a dispute with your insurance company over a claim. If there is no insurance payment activity after 60 days, we will ask for your payment and, of course, reimburse you if your insurance company later pays.

Patient responsibility payments (i.e., copays, co-insurance payments, payments towards deductible, etc.) are expected at the time of service. If payments have not been made for more than 2 consecutive weeks, without arrangements made with office staff, services may be put on hold until payments are settled. Our preference is to have a credit card on file, which will be charged at time of billing, typically within 24-48 hours of the visit. _____(initials)

Additional documentation (i.e., disability reports/questionnaires, school updates, school conferences, 504 plans, etc.) and extended phone conversations will be provided based on a time-based fee and will be the responsibility of the patient. _____(initials)

ATTENDANCE AND CANCELATION POLICY

Consistency in attendance to therapy is essential to making and maintaining progress.

Cancellation/Service Fees: We realize there may be circumstances that require you to cancel your appointment. When these situations occur, **please notify the therapy office at least 24 hours prior to your scheduled appointment.** With this notice, we may be better able to reschedule your therapy time and/or accommodate others waiting for therapy. **Cancellation without 24 hour notice will be assessed a \$48.00 cancellation fee.** If you cancel more than one therapy session with different therapists within the same day and without 24 hour notice, this \$48.00 fee will be assessed for each session missed. We understand emergencies do arise; in these situations notifications are still expected. Emergency situations

will be taken into consideration when assessing the cancelation fee. Messages may be left after hours through our voicemail system. _____(initials)

Attendance: Regular attendance is expected for therapy. If attendance falls below 75%, you may lose your regularly scheduled therapy time. If you miss more than 3 sessions without 24 hour notice, you may be discharged from therapy services. _____(initials)

Timeliness: If you arrive late for your session, the session may be canceled. Many sessions are scheduled for 30 minutes; if you are 10 minutes late to a session, valuable time is lost and we are often unable to accommodate. _____(initials)

Sick Policy: Please respect the health and wellness of all our clients, staff, and therapists. We expect you to be fever free and symptom free from illness for at least 24 hours in order to attend therapy sessions. _____(initials)

I understand that I am responsible for any charges not paid by my insurance coverage and I accept responsibility for any collection costs, attorney fees, and any other cost incurred that may result from nonpayment. I understand and agree to the above terms and conditions. I authorize my insurance company to pay my claims directly to Horn and Associates in Rehabilitation, PLLC.

Patient or Guardian (if minor) Signature

Date

Printed Name – Patient or Guardian (if minor)

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2023 Consent to Leave Voicemail and/or Email

Client Name: _____ Date of Birth: _____

Horn and Associates in Rehabilitation, PLLC, staff may contact you by telephone and/or email you with information such as appointment times, insurance, payment, diagnosis, records, examinations rendered to you and any other information soon your voicemail and/or email with your consent.

By signing this "Consent to Leave Voicemail and/or Email," you consent to Horn and Associates in Rehabilitation, PLLC, staff to leave messages and/or email detailed medical information to the phone number(s) and email(s) below. This information may include, but not limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, and medical information (diagnosis, records, evaluation results, etc.).

Home Phone: _____

Cell Phone: _____

Guardian Phone: _____

Email Address(s): _____

Do not leave any information on any phone number

Do not leave any information on any email address

I understand that Horn and Associates in Rehabilitation, PLLC, cannot require me to sign this consent form in order to receive treatment. I understand that I have the right to revoke this consent at any time. This consent is valid for a period of 12 months unless otherwise revoked. A copy of this consent form will be provided upon request.

Printed Name: _____

Client or Custodial Parent/Legal Guardian Signature: _____ Date: _____

Horn and Associates in Rehabilitation, PLLC

Speech and Language Therapy Questionnaire

Today's Date _____

Child's Name _____ Date of Birth _____

Describe the main speech/language difficulty in which you are seeking services.

Are there any medical/emotional/environmental factors that you believe contribute to the speech/language difficulty? If yes, please describe.

How does the child communicate (eye gaze, facial expressions, gestures, signs, augmentative communication system, vocalizations, simple words, phrases, sentences)?

How does the speech/language difficulty affect the child's behavior and ability to participate in daily activities?

Are there hearing concerns with the child? If so, please describe and indicate if a hearing test has been completed.

Feeding Concerns

Are there feeding concerns with the child? If so, please describe.

Please describe your child's abilities to transition from a bottle to a cup, transition to purees, and transition to table foods.

Is your child able to take food from a spoon/utensil? Finger feed? Feed self with utensils? Drink from an open cup? Drink from a straw?

Is drooling an issue with your child? If so, please describe. _____

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Does your child take a pacifier? Suck on fingers? Bite nails? _____

What are your child's preferred foods and textures? What textures/foods does your child refuse? Is gagging or vomiting present when trying non-preferred foods?

Describe any medical concerns with feeding, including history of reflux, allergies, GI issues, etc.

Academic Concerns

Are there academic concerns with the child? If so, please describe.

Please your child's educational history (i.e., schools attended, special services provided at school, etc.).

Does your child have difficulty following multiple step directions, remembering facts or details of stories, understanding the main idea of a story, or retelling a story?

What is your child's learning style? What are your child's strengths and weaknesses with learning?

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology,

laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, call 1-800-985-3059 (the federal phone number for information and complaints).

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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Notice of Privacy Practices

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

Your Health Information is Private.

Horn and Associates in Rehabilitation, PLLC (HRA) understands that information that we collect about you or your guardian's health/educational components is private. Keeping this information private is our most important responsibility. We are committed to protecting this information and following all laws regarding the use of this information. The law says: 1. We must keep your health information from other people who do not need to know it. 2. You may ask that we not share certain information. You must make your request in writing. In some instances, we may not be able to agree with your request. If that happens, we will explain the reasons to you. 3. You may ask that we contact you at a location you name (i.e. PO Box, work, mother's house) in the manner you prefer (i.e., phone or email). We may leave messages on your answering machine regarding appointments and we may call you by your name if you come into our office for an appointment.

Who Shares and Sees My or My Guardian's Health Information?

1. Your private health information may be used by healthcare providers such as doctors, therapists and nurses. They may need your private health information to plan your care.
2. We may share information about you in order to be paid for services. We send a bill to your insurance or other state/government programs (such as First Steps).
3. The bill has all of the information about the services you or your guardian had. We review healthcare information and bills to make sure that you get quality care and that all laws about providing and paying for your healthcare are being followed.
4. We share health information about you or your guardian on a need-to-know basis in order to help you receive services for you or your guardian.
5. We may also use information about you to evaluate how well we do our job and for other performance improvement activities.

May I See My Health Information?

You have the right to inspect your medical record and/or receive a copy of it as long as it does not interfere with your treatment. Your first copy is free; after that, there is a \$1.50 per page fee for additional copies.

What If I think Something In My Record Is Incorrect?

Our goal is to keep your information up-to-date and to correct inaccurate information. If you think any of the information is wrong, you may ask that it be changed or new information added - this is called an amendment. You may ask that the amendment be sent to anyone else who has received your health information from us. Your request must be in writing and submitted to the Privacy Officer, Dr. Donna Horn. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support your request. In addition, we may deny your request if you ask us to amend information that was not created by us, is not part of the information kept by or for us, and/or is accurate and complete. We must act within 30 days from the time we get your written request

Can I Limit Who Can See My or My Guardian's Information and Restrict Access to What They Can See?

You have the right to request restrictions on the information we or you disclose about you for evaluation, treatment, payment or healthcare operations. You also have the right to request a limit on the information we disclose about you or your guardian to someone who is involved in your or your guardian's care or the payment for your care. We are not required to agree, however, if we do agree, we will comply with your request.

What If I Need for My or My Guardian's Health Information to Go Somewhere Else?

You will be asked to sign a separate form called an Authorization Form allowing your healthcare information to go to someone else such as another provider. This authorization tells us what information is to be sent where and to whom. This Authorization is good for 1 year or until the date you put on the form. You can cancel the authorization or limit the information sent by letting us know in writing. After we receive your cancellation, we will not share any more information.

Can I Know Who Has Received Information About Me?

You may ask for a list, available in our charts, of any places where health information may have been sent.

Could My or My Guardian's Health Information Be Released Without My Authorization? There are times when by law we have to share private health information, even if you do not sign an Authorization Form. These include: 1. The abuse or neglect of a dependent adult and/or domestic violence offenses to the Department of Community Based Services. 2. Any instance of child neglect, exploitation or abuse to the Department for Community Based Services and/or police. 3. Any threats against persons to the intended victim and/or to the police.

We also must share information with: 1. Police or law enforcement reasons as required by law or in response to a court order. Law enforcement purposes include: a. limited information requests for identification and location purposes, b. pertaining to victims of crime, c. suspicion of death as a result of criminal conduct, and d. a medical emergency when a crime is likely to have occurred. 2. A coroner investigating any death. 3. The Federal Government when they are investigating something important to protect our country, the President of the United States, and/or other government officials.

How Do I File a Complaint?

If you think we have not protected your privacy and wish to complain, send your complaint in writing to: Privacy Officer, Dr. Donna Horn, 2412 Greatstone Point, Lexington, Kentucky 40504, 859/224-4081. You may also complain to the Federal Government by writing to the: Office of Civil Rights, US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201.

What Will Happen If I File a Complaint?

Absolutely nothing. It is against the law for us to take any retaliatory or other negative action against you or your guardian if you file a complaint.

We are required to abide by the terms of this notice, however, we reserve the right to change it. We reserve the right to make the revised notice effective for information we already have about you as well as future information we receive. All notices will have the effective date on them.
Effective Date: June 6, 2008