



Intake Documents

Welcome and Philosophy

Thank you for choosing the Openshaw SPOT therapy clinic as your provider. We extend you a warm welcome to you, your family, and friends. We consider it a privilege to serve you, this community, and assure you that your medical care, safety, and satisfaction are the most important to us. Please don't hesitate to ask us any questions you may have concerning your care and treatment.

Our Mission:

We provide our patients with high quality therapy services in a loving, caring and professional manner.

Our Vision:

We want to be considered the very best therapy clinic in Downeast Maine

Our Values

Advocacy; We will advocate for our clients, industry, providers and compliance.

Compassion; We believe that following a culture of compassion sets us apart.

Trust; We strive to be a trustworthy and responsible partner for parents and guardians of our patients, our referral and funding sources, and health care professionals who share in the responsibility of treating our patients.

Our Culture

To participate as an active part of the community and implement high standards to ensure that you are receiving the best care. Management and staff at all levels are assessing and updating your requirements so that the company is able to meet your physical, spiritual, social, emotional, and intellectual needs.



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Our Commitment to you:

This is in compliance with the Title VI of the Civil Rights Act of 1964 with section 504 of the Rehabilitation Act of 1973 with the Age Discrimination Act of 1975 and doesn't discriminate based on race, color, religion, sex, national origin, age or disability with regard to admission, access to treatment or employment. We will adhere to Section 1577 of the Affordable Care Act following state regulations.

We are committed to protecting your rights and privileges as a healthcare patient. Since many aspects of our services and procedures may be new to you, we have prepared this packet to help you become better acquainted with us, to assist you in understanding the therapy process, and explain your rights as a patient. As state and federal regulations change there may be additions or changes to this booklet. Our complete policy and procedure manual regarding your care and treatment is available to you upon request for your viewing at the office, or any time during normal business hours.

Business Hours:

Our official business hours are 8AM to 5PM Monday through Thursday. If you have any questions or concerns please contact our office at (207)-546-2880 or email us at office@theotspot.net Again, Thank you for choosing The Openshaw Spot

Cassandra Openshaw OTR/L
Occupational Therapist/CEO

Guardian Signature: _____

Client Name: _____

Date Signed _____



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Acknowledgement and Assumption of Risk

I Legal Guardian understands that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to have My child receive therapy services from The O.T. Spot, LLC and/or any employee or independent contractor employed by The O.T. Spot LLC I acknowledge that there are some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries. I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding The O.T. Spot, LLC and/or any employee or independent contractor employed by The O.T. Spot, LLC accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

Client Name: _____

Guardian Name: _____

By Signing I confirm I have read this page::

Signature: _____

Date: _____



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Attendance Policy

Attendance and Participation in therapy along with complete compliance with any associated home program is essential for therapeutic success. While The Openshaw Spot understands that illness and emergencies arise, we respectfully request that you avoid frequent cancellations or no shows. Please adhere to our following policy regarding providing our office with advanced notice for any cancellation resulting from a conflicting appointment, vacation, work obligations, or family and/or other events

- ALL cancellations must be submitted 24 hours before your scheduled appointment.
- If you cancel your appointment less than 24 hours in advance it will be considered a late cancel
- If you have 3 late cancel or no show appointments during your plan of care we reserve the right to discharge you from receiving services.
- Our office may put you on a scheduling hold for frequently canceled appointments

**We reserve the right to cancel all pending appointments and no longer serve you as a client.*

If you wish to reschedule please provide 24 hours notice and schedule your makeup appointment at your earliest convenience.

I, Legal Guardian understand the cancellation policy and the risks of not adhering to it:

Date Signed: _____ Signature: _____

Child Name: _____ Child's Date of Birth: _____



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Authorization to Exchange, Obtain or Release Information

Client/ Child's Full Name: _____

Client/ Child's Date of Birth: _____

Client/ Child's Address: _____

Client/ Child's Legal Guardian Name/s: _____

I, Client or Legal Guardian, hereby grant The O.T. Spot, LLC permission to communicate with the following person or agency:

Agency/ School Name: _____

Agency/ School Contact Information: _____

Type of Therapy to be Released (OT, ST, PT) _____

Information to be released: _____

Release this information for the purpose of: _____

I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax. I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

By Signing Here I agree to terms above:

Signature: _____ Date: _____



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Client Testimonial Permission Form

I, Legal Guardian, by execution of this Client Testimonial Permission Form hereby grant The O.T. Spot, LLC, its employees, designees, agents, independent contractors, legal representatives, successors and assigns the absolute right and unrestricted permission

Consent to Release

I hereby irrevocably authorize The O.T. Spot, LLC to copy, exhibit, publish or distribute my testimonial, for purposes of marketing, publicizing The O.T. Spot, LLC's services, or for any other lawful purpose. My may be used in printed publications, multimedia presentation, on websites or in any other distribution media. I waive any right to royalties or other compensation arising from or related to the use of my testimonial. I understand that while I am providing testimonial information to The O.T. Spot, LLC/ The Openshaw Spot, my treating healthcare provider shall not, at any time, provide any protected information to the media or to the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). I hereby hold harmless and release The O.T. Spot, LLC, its officers and employees from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Right to Revoke

I hereby acknowledge that I have the right to revoke this Release at any time by giving The O.T. Spot, LLC, written notice of my revocation and submitting it to The O.T. Spot, LLC. I understand that revocation of this Release will not affect any action that The O.T. Spot, LLC, has taken in reliance on this Release before receiving your revocation.

By signing below, I hereby acknowledge and agree that I have read and understand the above Release and agree to all terms described.

Signature: _____ Date Signed: _____

Legal Guardian: _____ Client Name: _____



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Communication Preference Form

Client/ Child Name: _____ Child DOB: _____

Today's Date: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to The O.T Spot, LLC to do the following:

Written Documentation and Verbal Information

I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.

I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

I grant permission to provide me with written communication via USPS in an unmarked envelope. I elect to receive clinical information in person or via telephone through the number provided.



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I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

By Signing I agree to the above methods of communication::

Date: _____

Signature: _____

Sharing of Information to other caregivers

Alternate Caregiver name: _____

Relationship to Client: _____

Email Address, Phone Number or other contact information: _____

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.:



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Client Email/ Texting Informed Consent

1. Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- d. Employers and on-line services have a right to inspect emails sent through their company systems.
- e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- f. Email and texts can be used as evidence in court.
- g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.



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2. Conditions for the use of email and texts

Therapists cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct.

Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

- a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
- d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
- e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
- f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
- g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.



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3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

I consent to receiving texts and email from staff at The O.T Spot, LLC:

Date: _____ Signature: _____

Clients Name: _____ Client Date of Birth: _____



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Consent for Observation

I, Legal Guardian, hereby grant The O.T. Spot, LLC and their consultants, contractors or employees to observe the child in the following setting(s): (school, home, community)

Other Setting Description: _____

I understand that during this observation, The O.T. Spot, LLC, their consultants, their contractors, or their employees may speak to providers, clinicians, teachers, employers, etc. about the client and I thereby grant permission for such discussions.

I am the client, parent or legal guardian of the person named below and have the legal authority to provide consent for observation.

Child's Name: _____

Date Signed: _____

Legal Guardian Signature: _____



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Informed Consent for Therapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with our office staff. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on you and your families willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. The Openshaw Spot will promise to support you and do our very best to understand you and your family as well as to help you clarify what it is that you want your child to achieve to become a happy healthy version of themselves.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.



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4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you.

Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

I authorize The O.T. Spot, LLC to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by The O.T. Spot, LLC in writing. In addition, The O.T. Spot, LLC may terminate services by notifying me in writing.

I consent for my child to receive therapy services they are scheduled for :

Date: _____ Signature: _____

Client Name: _____ Client Date of Birth: _____



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Insurance Information

The below information is true to the best of my knowledge. I authorize The O.T. Spot, LLC to directly bill my insurance company and I further authorize any third-party payer through which I have benefits to make payment directly to The O.T. Spot, LLC. I understand that I am financially responsible for any balance. I also authorize The O.T. Spot, LLC to bill my insurance company to use and disclose any healthcare information for the purpose of obtaining payment for services and determining insurance benefits. Services provided by outside companies, are billed separately by those companies

Primary Insurance Type: _____

Benefits Phone Number: _____

Insurance Member ID: _____

Insurance Group Number (if applicable): _____

If you do not know this information our office has it on your referral, feel free to ask us for help!

Patient's Date of Birth: _____

Patients Address: _____

Patients Physician: _____

Secondary Insurance Type: _____

Secondary Insurance Benefits Number: _____

Tertiary Insurance Type: _____

Tertiary Insurance ID number: _____



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I will update The O.T. Spot staff about any changes in insurance during our duration of care. I will provide staff with a copy of my insurance card.

I agree the information provided above is accurate and I give consent to bill my insurance for services rendered.:

Date: _____ Signature: _____

Client Full Name: _____



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The Openshaw Spot Credit Card Agreement for Private Insurance Clients ONLY

This Credit Card on File Agreement ("Agreement") is entered into on _____(date), between The Openshaw Spot hereinafter referred to as the "Clinic," and the patient/guardian, hereinafter referred to as the "Cardholder," for the purpose of facilitating payment for services rendered by the Clinic.

Credit Card Information: The Cardholder agrees to provide the Clinic with valid credit card information, including but not limited to cardholder name, credit card number, expiration date, and security code.

Authorization for Charges: By providing the credit card information, the Cardholder authorizes the Clinic to charge the credit card on file for any outstanding balances, co-payments, deductibles, or other fees associated with services rendered by the Clinic.

Scope of Authorization: The Cardholder understands and agrees that the Clinic will charge the credit card on file for all outstanding amounts owed to the Clinic. This includes charges for therapy sessions, evaluations, administrative fees, missed appointments, late cancellations, or any other services provided by the Clinic.

Notification of Charges: The Clinic agrees to notify the Cardholder in writing or via email of any charges made to the credit card on file within a reasonable time frame.

Dispute Resolution: In the event of a disputed charge, the Cardholder must notify the Clinic within 30 days of receiving the statement containing the disputed charge. The Clinic will investigate the dispute and work with the Cardholder to resolve the issue in a timely manner.

Updating Credit Card Information: The Cardholder agrees to promptly notify the Clinic of any changes to the credit card information on file, including changes to the card number, expiration date, or billing address.

Termination of Agreement: The Cardholder may terminate this Agreement at any time by providing written notice to the Clinic. Upon termination, the Clinic will remove the credit card information from the Cardholder's file.



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Declined Payment and Service Hold: In the event that a payment charged to the credit card on file is declined or not received, the Clinic reserves the right to place services on hold until payment is received. Additionally, the Clinic reserves the right to discharge the client from further services if outstanding balances remain unpaid for an extended period of time, as determined by the Clinic in its sole discretion.

Confidentiality: The Clinic agrees to maintain the confidentiality and security of the credit card information provided by the Cardholder in accordance with applicable laws and regulations.

Governing Law: This Agreement shall be governed by and construed in accordance with the laws of Maine, without regard to its conflicts of law provisions.

Entire Agreement: This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements and understandings, whether written or oral, relating to such subject matter.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

I, the undersigned Cardholder, hereby acknowledge that I have read and understood the terms and conditions of this Agreement and agree to be bound by them.

Cardholder's Signature: _____

Full Name: _____

Name on Credit Card: _____

Card Number: _____

Expiration Date: _____

3 Digit Code: _____

Date: _____



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Insurance Non-Coverage

In the event that you have been admitted with the understanding that Medicaid/ Private Insurance will pay for your care and it is determined that Medicaid and/or private insurance will not pay for your current services, you will be advised of the effective date that services will cease. You will be given the opportunity to assume responsibility for the cost of the services. If you choose to discontinue receiving services, you will be given notice of the date on which your services will cease.

If you choose to appeal then you have the right to an immediate, independent medical review (appeal) while your services continue.

Both you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should continue. You will receive this detailed notice only if you have requested an appeal

If you choose to appeal, the independent reviewer will ask for your opinion, review your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.

If the independent reviewer agrees with the determination that services should no longer be covered after the effective date you were given, then you either stop services no later than the effective date or accept financial liability for the services.

To begin the appeal process, call the office at (207)-546-2880

By signing below I understand that if insurance is not covering my services I will be financially responsible.

Date: _____ Signature: _____



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Client/ Child's Name: _____ Client Date of Birth: _____

Conflict Resolution Problem Solving

The services provided for you at The O.T. Spot, LLC are in collaboration with your doctor. A Plan of Care will be established between your doctor, our licensed care staff, yourself and your family, if you so choose. These services may be provided for you under Medicaid or other health insurance, We are able to assist you in coordinating benefits for your therapy needs.

We are committed to ensuring that your rights are protected. If you feel that our staff has failed to follow our policies or in any way denied you your rights or discriminated against you; please follow these steps without fear or discrimination of reprisal:

1. Contact the Clinical Manager at the number listed above.
2. If you feel satisfactory action has not been taken, you may contact the Section 504 Coordinator at the following:

The Office for Civil Rights, US Department of Health and Human Services Hotlines:
1-800-368-1019

E-Mail: ocrmail@hhs.gov

Website: <http://www.hhs.gov/ocr>

Date: _____ Signature: _____

Client/ Child's Name: _____ Client Date of Birth: _____



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Notice of Privacy Practices HIPAA

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how The O.T. Spot, LLC may use or disclose your child's protective health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and refuse the release of specific information outside of this system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice

You will be asked to provide a signed acknowledgement of receipt of this notice. The intent is to make you aware of the possible uses and disclosure of your child's protected health information and your privacy rights. The delivery of your child's health care services will in no way be conditioned upon your signed acknowledgement.

Who Will Follow this Notice

This notice applies to all therapy services provided by The O.T. Spot, LLC. It also applies to office personnel and billing personnel.

Our Responsibility Regarding Protected Health Information

Your child's protected health information is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your child's past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

- Make sure that your child's protected health information is kept private.
- Give you this notice of our legal duties and privacy practices related to use and disclosure of your child's protected health information.
- Follow the terms of the notice currently in effect.



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- Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about your child as well as any information received in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the top of this notice.

Our System

The O.T. Spot, LLC works with several agencies and referral sources. Your child's health information will be shared in the following manner:

1. Treatment- we will use and disclose your child's protected health information to provide, coordinate, or manage your child's health care and any related services. This includes disclosure to your physician or other health care providers who become involved in your child's care.
2. Within my office for administrative activities, quality assessment, oversight and peer review.
3. With my billing personnel and as necessary to obtain payment for your services.
4. With your insurance company or other payers as required for payment.
5. With the referring agency and case manager if applicable,
6. With any other provider, school or agency with your written request, You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

The O.T. Spot, LLC may use or disclose your child's protected health information if law or regulation requires the use or disclosure.

The O.T. Spot, LLC will notify the appropriate government authority if they believe a patient has been the victim of abuse, neglect or domestic violence. Health Oversight
The O.T. Spot, LLC may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.



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These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs

and civil right laws. Legal Proceedings The O.T. Spot, LLC may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.

Required by Law

The O.T. Spot, LLC may use or disclose your child's protected health information if law or regulation requires the use or disclosure. The O.T. Spot, LLC will notify the appropriate government authority if they believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight

The O.T. Spot, LLC may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

Legal Proceedings

The O.T. Spot, LLC may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.

Parental Access

The O.T. Spot, LLC may disclose your child's protected information to parents, guardians and persons acting in similar legal status.

Uses and Disclosures of Protected Health Information Requiring Your Permission



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In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your child's protected health information. Since this service is provided in your home or other natural environments, those present during the session, including friends, family, or day care providers may hear health information regarding your child. Please notify your therapist if you do not want your child's protected health information to be discussed.

Your Rights Regarding Your Child's Health Information

You may exercise the following rights by submitting a written request to The O.T. Spot office.

1. You may inspect and obtain a copy of your child's protected health information that is key as a part of the medical and billing records.
2. You may ask me not to use or disclose any part of your child's health information for treatment, payment or healthcare operations. Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm your child.
3. You may request that The O.T. Spot, LLC communicates with you using alternative means or at an alternative location. We will not ask you the reason for your request, we will accommodate reasonable requests, when possible,
4. If you believe that the information we have about your child is incorrect or incomplete, you may request an amendment to your child's protected health information as long as we are responsible for and maintain this information. While we will accept requests for amendment, we are not required to agree to this amendment.
5. You may request that The O.T. Spot, LLC provide you with an accounting of the disclosures we have made of your child's protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in the Notice of Privacy Practices. This disclosure must have been made after April 21, 2010, and no more than six years from the date of request. This right excludes disclosures made to you or authorized by you, to family members,



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or friends involving in your child's care, or for notification. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this notice.

Federal Privacy Laws

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing policies and this notice of how I will use and disclose your child's protected information.

Complaints

If you believe these privacy rights have been violated, you may file a written complaint with the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

This notice is effective in its entirety as of January 1, 2025

I have read HIPAA privacy laws Signature: _____

Date Signed: _____

Client name : _____

Client Date of Birth: _____



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Parent Involvement in the Therapy Process

Infants and toddlers with impairments requiring speech and/or occupational therapy, also require an alliance between the parents and therapist. Most therapy sessions include demonstration of techniques to parents so that they can follow through with observed and recommended activities at home. Your child requires your assistance in order to progress.

If you work full time and have a regular child care provider, you may provide permission for your child's child care provider to be present in your place for some of the occupational therapy sessions.

Providers will make every effort to schedule sessions for a time that is convenient to one or both parents and when your child is most ready to work.

The O.T. Spot, LLC is not affiliated with a Home Health Care Agency and so if your child receives Home Health Care nursing, you should understand that The O.T. Spot, LLC does not have a contractual relationship which would allow them to extend there services through nurse care providers who are not related to your child. Nurse care providers are certainly welcome to be present and observe therapy sessions and they can follow through with any recommended activities that you request. Nurse care providers cannot be a substitute for your presence.

The O.T. Spot, LLC understands the challenges related to meeting scheduled appointments. If you cannot be present for your child's occupational therapy session please cancel your appointment within 24 hours of the scheduled time.

You may call and leave a message at (207) 546-2880.

I have read and understand the importance of parent involvement in the therapy process:



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Signature: _____

Date: _____

I give permission to, Other Representative*, to attend occupational therapy sessions with my child when neither of his/her parents are available to attend. The O.T Spot, LLC has my permission to share any relevant medical information necessary to provide services and instruct my representative in home exercise programming.

Other Representative: _____

Patient Name: _____



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Consent and Release of Photographs/ Videos

Client/ Child's Name: _____

Client/Child's Date of Birth: _____

Legal Guardian Full Name: _____

Consent for Videos/ Photos: _____

I acknowledge that I will receive no financial compensation for providing consent since my participation with The O.T. Spot, LLC in providing my consent and release is voluntary.

I hereby release The O.T. Spot, LLC , their contractors, their employees and/or any third parties involved in the creation or publication of The O.T. Spot, LLC Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

Signature: _____

Date: _____

- Leave the signature blank if you do not wish your child to be photographed or videotaped



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SLP Supervision letter

Dear Speech Therapy Client,

This letter is to inform you that our speech services may be provided by a speech therapy assistant Courtney Hall, SLPA. Her supervisor is Speech Language Pathologist Kassidy Seavey, CCC-SLP. Courtney is providing direct therapy under Kassidy's license.

Scope of Responsibilities of Speech-Language Pathology Assistants

1. Provided that the training, supervision, documentation and planning are appropriate, the following tasks may be delegated to a speech-language pathology assistant:

A. Conducting speech-language screenings (without interpretation) following specified screening protocols developed by the supervising speech-language pathologist.

B. Providing direct treatment assistance to clients identified by the supervising speech-language pathologist.

C. Following documented treatment plans or protocols developed by the supervising speech-language pathologist.

D. Documenting client progress toward meeting established objectives as stated in the treatment plan, and report this information to the supervising speech-language pathologist.

E. Assisting the speech-language pathologist during assessment of clients, such as those who are difficult to test.



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F. Assisting with informal documentation (e.g. tallying notes for the speech-language pathologist to use), prepare materials, and assist with other clerical duties as directed by the speech-language pathologist.

G. Scheduling activities, prepare charts, records, graphs, or otherwise display data.

H. Performing checks and maintenance of equipment.

I. Participating with the speech-language pathologist in research projects, in-service training and public relations programs.

2. A speech-language pathology assistant may not:

A. Perform standardized or nonstandardized diagnostic tests, formal or informal evaluations or interpret test results.

B. Participate in parent conferences, case conferences, or any interdisciplinary team without the presence of the supervising speech-language pathologist.

C. Provide client or family counseling.

D. Write, develop, or modify a client's individualized treatment plan in any way.

E. Assist with clients without following the individualized treatment plan prepared by the speech-language pathologist or without access to supervision.

F. Sign any formal documents (e.g. treatment plans, reimbursement forms, or reports). The assistant should sign or initial informal treatment notes for review and co-signature by the supervising professional.

G. Select clients for services.

H. Discharge a client from services.

I. Disclose clinical or confidential information, either orally or in writing, to anyone not designated by the supervising speech-language pathologist.



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J. Make referrals for additional services.

K. Communicate with the client, family, or others regarding any aspect of the client's status without the specific consent of the supervising speech-language pathologist.

L. Represent himself/herself as a speech-language pathologist.

6. Exclusive Responsibilities of the Speech-Language Pathologist

1. Documenting the pre-service training, competencies and credentials of the Assistant.

2. Informing patients/clients and families about the level (professional vs. support personnel), frequency, and duration of services as well as supervision.

3. Representing the speech-language pathology team in all collaborative, interprofessional, interagency meetings, correspondence and reports. This would not preclude the Assistant from attending meetings along with the speech-language pathologist as a team member or drafting correspondence and reports for editing, approval and signature by the speech-language pathologist.

4. Making all clinical decisions, including determining patient/client selection for inclusion/exclusion in the caseload and dismissing patients/clients from treatment.

5. Communicating with patients/ clients, parents and family members about diagnosis, prognosis and treatment plan.

6. Conducting diagnostic evaluations, assessments or appraisals, and interpreting obtained data in reports.

7. Reviewing each treatment plan with the assistant at least weekly.

8. Delegating specific tasks to the assistant while retaining legal and ethical responsibility for all patient/client services provided or omitted.



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9. Preparing an individualized treatment plan and making modifications prior to, or during, implementation.
10. Discussing the case with, or referring the patient/client to, other professionals.
11. Signing all formal documents (e.g. treatment plans, reimbursement forms, reports). The supervisor should indicate on the documents that the assistant performed certain activities.
12. Reviewing and signing all informal progress notes prepared by the assistant.
13. Providing ongoing training to the assistant on the job.
14. Ensuring that the assistant only performs tasks within the scope of responsibility of the speech-language pathology assistant.

Thank you,

The Openshaw Spot

(207)-546-2880

I have received this notice: _____

Date: _____



Intake Documents

Telepractice Consent Form

Telepractice is the delivery of therapy services using distance technology, typically computers, when the clinician and patient/client are not in the same physical location.

Potential Benefits:

1. Allow for remote therapy services either by choice or when in-person services aren't available.
2. Provide education and support to caregivers to foster carryover.
3. Allow for greater convenience for all parties and reduction of cancellations.

Potential Risks: As with any service, there may be potential risks associated with the use of telepractice.

These risks include, but may not be limited to:

1. Quality and strength of Internet connection may vary and/or may not be sufficient for high-quality video and audio to allow for effective interaction.
2. Security protocols of the Internet-based programs could fail, causing a breach of privacy of confidential clinical/medical information.

By signing this form, I understand and agree with the following:

The laws that protect the privacy and confidentiality of health information also apply to telepractice. Information obtained during telepractice sessions will not be given to anyone without my consent. As with any Internet-based communication, I understand



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that there is a risk of security breach. I have the right to withhold or withdraw my consent to the use of telepractice.

I have the right to inspect any information obtained and/or recorded through telepractice.

I may expect the anticipated benefits from the use of telepractice, but I understand that no results can be guaranteed.

I hereby consent to the use of telepractice in the provision to my child's therapy services:

Date: _____ Signature: _____

Child's Name: _____

Child's Date of Birth: _____