1815 NW169th Place, Suite 3070
Beaverton, OR 97006
Ph 971-249-2653
Fax 503-747-4373

BOLD Pediatric Therapy Center
Welcome Letter

Welcome to BOLD Pediatric Therapy Center. We offer occupational therapy, speech therapy and physical therapy services for children ranging from birth to 21 years of age. Through our therapy process, we support development and independence towards success with challenge areas that you and your child are experiencing.

We are located on the south side of Cornell road, in the Twin Oaks Business park, across the road from Dania Furniture. We are easily accessible south of highway 26 off 185th street or 158th street in Beaverton. Our address is 1815 NW 169th Place, Suite 3070, Beaverton Oregon, 97006. From Cornell turn onto 169th Place and drive to the end of the cul-de-sac to find parking immediately in front of the building.

We have partnerships with many insurance companies to ensure in network benefit access. We are in network with the following health insurance plans:

- Providence Health Plan (all Providence Health Plans except Neighborhood)
- Regence Blue Cross, Cigna Health Plans, (including Cigna Intel), Moda Health Plans, (including Moda OHSU).
- Kaiser Permanente for speech therapy services with individual contracts.

We will submit claims to out of network plans on your behalf if your plan allows for out of network benefits.
We accept private payment for all services and offer a discounted rate as we are able reduce our administration processing costs.

If you wish to continue to collaborate with BOLD Pediatric Therapy Center to be part of your team in support of your child, please complete the following registration form and return by fax or email, or mail (only pages 2 and 3) to begin the process of scheduling an appointment.

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www.boldpediatrictherapy.com

Client Registration Form

Child's Name:	Child's Date of Birth:
Preferred name or nickname:	Primary email for communication:
Parent/Guardian Information (1) - Name:	Relationship:
Home Phone:	Cell Phone:
Guardian Information (2): - Name:	Relationship:
Home Phone:	Cell Phone:
Street Address: *Must be complete*:	Mailing Address *if different*:
Primary Care Physician(Pediatrician):	Child's diagnosis *(if known)*:
MD Phone:	Who recommended BOLD Center?

Insurance Information: Please Scan and attach copy of Insurance Card(s)

Primary Ins Plan Name:	Name of Insured: (usually parent)	Insured Date of Birth:
Child's I.D. Number:	Insured relationship to child:	Insurance Plan Group Number:
Secondary Ins Plan Name:	Name of Insured:(usually parent)	Insured Date of Birth:
Child's I.D. Number:	Relationship to child:	Insurance Plan Group Number:

Clinical Intake Information

Please list in detail the reason you want services at BOLD Center include the concerns and challenges for your child:

Has your child previously had a therapy evaluation or treatment?

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Physical Therapy

Evaluation date:

Treatment dates:

Location:

What are your all your available days and times for treatment with your child?

☐ M ☐ T ☐ W ☐ TH ☐ F

☐ AM between _____ & _____ ☐ PM between _____ & _____

Terms/Conditions for Services

I hereby authorize Bold Pediatric Therapy Center, to release and/or obtain information concerning the patient's present condition with the above-named insurance company. The undersigned authorizes the release of any information relating to all claims for benefits submitted on my behalf and/or my dependents through a billing service. I further agree and acknowledge that my signature on this document authorizes Bold Pediatric Therapy Center, to submit claims for benefits and for services rendered without obtaining my signature on each and every claim. I also acknowledge that co-payments are due at the time of service and any insurance balance over 90 days becomes my responsibility.
Initial here_____

I acknowledge receipt of Bold Pediatric Therapy Center's Notice of Privacy Practices and the protection of healthcare information.
Initial here_____

I give my consent for Bold Pediatric Therapy Center to diagnose and provide therapy treatment to my minor child, (Name)_____. This authorization is valid until revoked in writing.

_____	_____	_____
Date	Parent or guarantor signature	Parent or guarantor printed name

By typing my name below, I acknowledge that is equivalent to a hand-written signature.

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Notice of Privacy Practice

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

You have the right to:

- Get a copy of your paper or electronic medical records
- Correct your paper or electronic medical records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

See Page 4 for more information on these rights and how to exercise them

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

See page 5 for more information and how to exercise them

We may use and share your information as we:

- Treat you
- Run our organization
- Bill your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with medical examiners or funeral directors
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

See page 5 and 6 for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get and electronic or paper copy of your medical records

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical records

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do it.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to a reasonable request.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of the times we've shared your health information for six years prior to the date you asked, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.
- We will not retaliate against you for filling a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- share information in a disaster relief situation
- include your information in a hospital directory

if you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the care of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you:

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our Organization:

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

Bill for your services:

- We can use and share your health information to bill and get payment for health plans or other entities.
  Example: We give information about you to your health insurance plan, so they will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

- For health research.
- If state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Organ procurement organizations.
- Coroner, medical examiner, or funeral director when an individual dies.
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- In response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy of security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other that as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the terms of notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This Notice of Privacy Practice applies to the following organizations.

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