Welcome!

The Pediatric Outpatient Clinic at Easter Seals RI is pleased to be of service to you and your family. We offer highly qualified professional personnel dedicated to providing services necessary for the Pediatric Development and Therapy of young children and the support and education for their families.

Enclosed please find general information about Easter Seals RI. Also enclosed is an intake packet with the signature forms necessary for services to begin. Please fill out these forms and bring them to your child's initial visit to our clinic.

If you have any questions regarding the enclosed forms, please feel free to contact me at
284-1000

Welcome to The Pediatric Outpatient Clinic at Easter Seals RI.

Sincerely,

Patricia O'Leary MSPT
Clinical Supervisor

Enclosures

How we determine frequency of therapy for children
Easter Seals RI Outpatient Clinic

What are the goals of therapy?

Although goals for each child will vary with their development and abilities, a child is referred to therapy to accomplish a certain outcome or goal. For example, a child referred might be referred to physical therapy for a delay in motor development-one goal might be that the child walks independently. A child might be referred to speech therapy because his speech is not easy to understand-one goal might be that the child can say a specific sound so that they are understood when speaking.

Goals must be *achievable, measurable, and functional.*

Achievable- the goal must be appropriate for the child, given their developmental stage and any limitations

Measurable- the goal must be able to be observed

Functional- the goal must relate to skills necessary to function in school or in life

Parent input is important to determine which goals are most important for the child and family. Children achieve more when parents and therapist work together to determine the goals and to treat children so they can achieve their goals.

How often will the therapist work with the child and family?

Therapists help determine which activities help the child reach their goals. Therapists also work with families, showing them activities that the child should be completing regularly at home. These home exercises are very important, as a child spends much more time at home then they will in therapy, and at home or out in the community the child will have the opportunity to practice and develop their skills. Most treatment should occur outside of therapy after treatment exercises have been learned by the child and the family. Strategies learned at therapy should be implemented through everyday activities.

Therapy sessions are needed to evaluate children, work with families to develop activities that benefit the child, and to progress these activities. Some children at some stages will require frequent therapy due to quickly changing abilities. Other children will require less frequent therapy, as their activities may not change frequently, and progress towards goals occurs over longer periods of time.

We use four different frequencies of treatment:

Intensive-3+ visits each week

This is for children who have immediate and complex needs, and who are quickly achieving their goals. For example, a child with complex medical issues who has just returned home following surgery.

Weekly/bimonthly-1-2x/week to 1x/2 weeks

This is for children who need frequent therapy and are continually making progress towards their goals.

Periodic-monthly or at regularly scheduled intervals

This is for children who show slower progress towards their goals. Visits with the therapist are used to track progress and update a home exercise program.

Consultative-as needed

This is for children who require intermittent updates to equipment, to determine need for further therapy, who have progressed developmentally, or who have undergone medical intervention.

The frequency of treatment will change over time. Once a home exercise program is established, visits with therapists may focus more on evaluation and treatment strategies that can be carried out at home.

Discharge occurs when:

Goals have been achieved.
The family chooses not to continue therapy.
Therapy does not produce a functional and measurable outcome.

How is outpatient-based therapy different from school-based therapy?

Outpatient-based therapy and school-based therapy may differ in models of treatment, treatment goals, and duration of treatment. Along with one-on-one treatment, school-based therapists may work with groups of students. Treatment goals for school-based therapy focus on school-based tasks, such as the ability to write, or to move between one classroom and another. Although many of the goals will overlap between settings, outpatient-based therapy may focus

on tasks that wouldn't be required at school. For example, although a child may be able to move between classes with a wheelchair, outpatient therapy may focus on adapted walking.

One of the biggest distinctions between outpatient-based and school-based therapy is the duration of treatment. School-based therapy generally continues as long as there is an achievement gap between the child and classmates, or until staff can implement therapy techniques without the therapist present. Outpatient-based therapy concludes when the child's progress plateaus, or when the family can implement therapy techniques without the therapist present. This is why a child may continue with school-based therapy (because they are not at age-level in their development), but would no longer require outpatient-based therapy (because parents and caregivers can continue exercises/strategies at home and further evaluation or input from a skilled therapist is no longer needed).

Should the parent attend the child's treatments?

Yes! A child spends much more time at home then they will in therapy. At home and out in the community, the child will have the opportunity to practice and develop their skills. It is important for families to discuss goals and treatment techniques with the therapists including exercises to work on at home that will best help the child reach their goals. Therefore, a parent/caregivers' presence during their child's therapy is important so they can ask questions and develop strategies to further their child's development.

BILLING INFORMATION

If you have any questions regarding the charges for services, please contact your local office. If you are not insured and are unable to personally meet the charges, special financial arrangements may be made through the Billing Office .

If you are covered by:

1. **PRIVATE INSURANCE**: You are expected to handle all insurance matters, including appropriate referrals, unless alternative arrangements are made in advance. Our contract is with the client, not the insurance company. You should check with your health plan, our billing office and your therapist to determine how many visits have been authorized. You may also be responsible for a "co-pay" or deductable payment which is determined by your health plan.

2. **MEDICAID:** A doctor's referral is required. The bill will be sent directly to the Office of Medical Services. If your Medicaid coverage is discontinued, you must notify the Easter Seals RI immediately.

3. **GRANTS/REFERRING AGENCY:** For services to be funded by a grant of a referring agency, the bill will be sent directly to the funding source.

If you have questions about your account, please contact the Billing Office. We are there to help.

401-284-1000 or
603-621-3463

CO-PAYS / DEDUCTIBLES / CO-INSURANCE

As a contracted provider with most major insurance companies, Easter Seals RI is required to comply with all policies and practices that govern our contractual agreements with insurers. As such, we want to ensure that you are aware of your responsibility in paying these costs as identified in your policy. All co-pays must be paid at the time of each visit. Any costs as a result of unmet deductibles, uncovered services or denied benefits will be billed to you. Your required signature on the application for services confirms your acceptance of financial responsibility. An outstanding balance of greater than three months may result in termination of services.

It is also critical to notify the office immediately with any changes in insurance coverage to avoid being billed for the full cost of services.

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Thank you for your business and please understand that the quality services provided to your child are contingent of the revenues generated.

Easter Seals Rhode Island
213 Robinson Street
Wakefield, RI 02879
(4010 284-1000

Account #_____

APPLICATION FOR SERVICES

CLIENT INFORMATION

Name:_____
(Last) (First) (MI)

Address:_____

_____

Phone:_____ SS#_____

Referral Source:_____

Address:_____

_____ Phone:_____

Marital Status: S M W D Sex: M / F

Age:_____ DOB:_____

Emergency Contact:_____

_____ Phone:_____

Diagnosis:_____

_____

RESPONSIBLE PAYOR INFORMATION

Name:_____
(Last) (First) (MI)

Address:_____

_____

Phone:_____ SS#_____

Employer's Name:_____

Address:_____

_____

Phone:_____

BILLING INFORMATION

Primary Insurance:_____

Insurance #:_____

Policy Holder's Name:_____

Policy Holder's DOB:_____

Secondary Insurance:_____

Insurance #:_____

Policy Holder's Name:_____

Policy Holder's DOB:_____

~ Terms of Agreement ~

REQUEST AND AUTHORIZATION FOR TREATMENT: I hereby request and authorize the medical director and/or the clinical or service-oriented staff of Easter Seals Rhode Island to administer all diagnostic and treatment procedures or services as is required for the above named client.
RELEASE OF INFORMATION: I further authorize the release of medical and other information necessary for completion of my claims, if any, for insurance or compensation benefits.
Is your child receiving OT/PT/SP services elsewhere? Yes __ NO__ Are these services being billed to your insurance? Yes__ NO___

_____ _____
Client / Parent / Legal Guardian Date Witness Date

FINANCIAL RESPONSIBILITY: I hereby assign unto Easter Seals Rhode Island all health insurance benefits now due and to become due and payable to me by virtue of my treatment by said Agency, and I hereby direct my insurance carriers to pay such benefits directly to such Agency in consideration of the services furnished and to be furnished by said Agency.
I understand that I remain financially responsible to Easter Seals Rhode Island for charges not paid by my insurance carrier.
Moreover, I understand that if I fail to meet any financial responsibilities as stated in these terms, I am responsible for the legal fees incurred by the Agency in its effort to collect any money due on my account.

_____ _____
Responsible Payor Date Witness Date

EMERGENCY/MEDICAL INFORMATION

Services Requested:				
		Behavioral Health		Occupational Therapy
		Physical Therapy		Speech Therapy

CLIENT NAME:_____ DOB:_____ SS#_____

ADDRESS:_____
(street) (city) (state) (zip)

Parent(s)/Legal Guardian:_____

Home #_____ Work #_____ Cell #_____

E-Mail Address:_____

Diagnosis (if applicable):_____

Pertinent History/Health Complications/Illnesses/Infections/Precautions/Allergies:_____

_____

_____

_____

_____

Primary Healthcare Practitioner:_____

Address:_____
(street) (city) (state) (zip)

Phone #_____

Specialists (orthopedist, neurologist, ENT, etc.):_____

_____Preferred Hospital:_____

If in case of an emergency, I hereby authorize Easter Seals RI (or their representative) to take whatever action is necessary for the above named individual.

_____

Signature of Parent or Legal Guardian Date

In the event of an emergency, please contact:

Name	Relationship	Home Phone	Work or Cell Phone

Background Information

Reason for requesting services (be specific about any concerns):_____

_____

_____

Complications, illnesses/infections/stress during pregnancy? Y / N (describe)_____

_____

Easter Seals Rhode Island
213 Robinson Street
Wakefield, RI 02879
401-284-1000
401-284-1006 (FAX)

Pediatric Outpatient Background Information

Date: _____

Client Name:_____ Parent/ Guardian Name (s):_____

DOB:_____ Age:_____

Address:_____ Parents/Guardian Address: Same_____

_____ _____

Contact phone: _____(H) _____(C)_____(W)

Sex: M F Height:_____ Weight:_____ Handedness: R L N/A

Referred by;_____ Reason for referral:_____

Date of Onset:_____ Occurrence of Onset:_____

_____

Significant birth/pregnancy history:_____

_____

Any significant developmental delays:_____

Family/Caregiver primary concern:_____

School/Work: _____ Is there and IEP in place? Y N

Other Service Agencies:_____

Does the child receive PT/OT from other agencies? Y N Frequency and duration_____

Leisure time interests and hobbies:_____

Medical History

Surgeries/ Hospitalizations:

Date:_____ Event:_____

Date:_____ Event:_____

Other significant episodes:_____

Health Related Concerns:

Respiratory: frequent colds?_____ ear infections? _____allergies or asthma?_____

Other related respiratory concerns?_____

Sleep patterns: _____

Cardiovascular: BP? _____ heart defects? _____arrhythmias? _____

Other cardiovascular/circulatiory?_____

Metabolic concerns: diabetes? _____ Other? _____

Head aches? _____

Complaints of pain? _____

Complaints of fatigue? _____

Seizures?_____

Medications:

Other relevant clinical tests/evaluations relevant to diagnosis: _____

_____

Orthotics and/or adaptive equipment: _____

_____

Communication:

Concerns with hearing? _____

Is able to understand verbal direction? _____ gestures? _____

Requires augmentative communication? _____

Speech? _____

Ability to make needs known? _____ How? _____

Vision: Glasses? Y N _____

_____

_____

Behavioral/cognitive:

Special strategies to facilitate cooperation / understanding? _____

_____

Additional Comments:

_____

_____

_____

Information provided by: _____

CANCELLATION POLICY

PURPOSE:

To minimize client cancellations and "no shows" in order to maximize effective and efficient treatment.

POLICY STATEMENT:

In order to provide effective treatment programs, the client must make every effort to attend scheduled appointments.

Excused absences or cancellations should be called in to the appropriate department 48 hours in advance. Clients will be discharged from the therapy program following two (2) absences or "no shows" without prior notification.

Thank you in advance for your cooperation.

_____ _____

Parent/Guardian Signature Witness Signature

_____ _____

Date Date

TITLE 23
Health and Safety

CHAPTER 23-17
Licensing of Health Care Facilities

SECTION 23-17-19.1

§ 23-17-19.1 Rights of patients. – Every health care facility licensed under this chapter shall observe the following standards and any other standards that may be prescribed in rules and regulations promulgated by the licensing agency with respect to each patient who utilizes the facility:

(1) The patient shall be afforded considerate and respectful care.

(2) Upon request, the patient shall be furnished with the name of the physician responsible for coordinating his or her care.

(3) Upon request, the patient shall be furnished with the name of the physician or other person responsible for conducting any specific test or other medical procedure performed by the health care facility in connection with the patient's treatment.

(4) The patient shall have the right to refuse any treatment by the health care facility to the extent permitted by law.

(5) The patient's right to privacy shall be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility. Nothing in this section shall be construed to preclude discreet discussion of a patient's case or examination of appropriate medical personnel.

(6) The patient's right to privacy and confidentiality shall extend to all records pertaining to the patient's treatment except as otherwise provided by law.

(7) The health care facility shall respond in a reasonable manner to the request of a patient's physician, certified nurse practitioner and/or a physician's assistant for medical services to the patient. The health care facility shall also respond in a reasonable manner to the patient's request for other services customarily rendered by the health care facility to the extent the services do not require the approval of the patient's physician, certified nurse practitioner and/or a physician's assistant or are not inconsistent with the patient's treatment.

(8) Before transferring a patient to another facility, the health care facility must first inform the patient of the need for and alternatives to a transfer.

(9) Upon request, the patient shall be furnished with the identities of all other health care and educational institutions that the health care facility has authorized to participate in the patient's treatment and the nature of the relationship between the institutions and the health care facility.

(10) Except as otherwise provided in this subparagraph, if the health care facility proposes to use the patient in any human subjects research, it shall first thoroughly inform the patient of the proposal and offer the patient the right to refuse to participate in the project.

(b) No facility shall be required to inform prospectively the patient of the proposal and the patient's right to refuse to participate when: (i) the facility's human subjects research involves the investigation of potentially lifesaving devices, medications and/or treatments and the patient is unable to grant consent due to a life-threatening situation and consent is not available from the agent pursuant to chapter 23-4.10 of the general laws or the patient's decision maker if an agent has not been designated or an applicable advanced directive has not been executed by the patient; and (ii) the facility's institutional review board approves the human subjects research pursuant to the requirements of 21 CFR Part 50 and/or 45 CFR Part 46 (relating to the informed consent of human subjects). Any health care facility engaging in research pursuant to the requirements of subparagraph (b) herein shall file a copy of the relevant research protocol with the department of health, which filing shall be publicly available.

(11) Upon request, the patient shall be allowed to examine and shall be given an explanation of the bill rendered by the health care facility irrespective of the source of payment of the bill.

(12) Upon request, the patient shall be permitted to examine any pertinent health care facility rules and regulations that specifically govern the patient's treatment.

(13) The patient shall be offered treatment without discrimination as to race, color, religion, national origin, or source of payment.

(14) Patients shall be provided with a summarized medical bill within thirty (30) days of discharge from a health care facility. Upon request, the patient shall be furnished with an itemized copy of his or her bill. When patients are residents of state-operated institutions and facilities, the provisions of this subsection shall not apply.

(15) Upon request, the patient shall be allowed the use of a personal television set provided that the television complies with underwriters' laboratory standards and O.S.H.A. standards, and so long as the television set is classified as a portable television.

(16) No charge shall be made for furnishing a health record or part of a health record to a patient, his or her attorney or authorized representative if the record or part of the record is necessary for the purpose of supporting an appeal under any provision of the Social Security Act, 42 U.S.C. § 301 et seq., and the request is accompanied by documentation of the appeal or a claim under the provisions of the Workers' Compensation Act, chapters 29 – 38 of title 28. A provider shall furnish a health record requested pursuant to this section within thirty (30) days of the request. Further, for patients of school based health centers, the director is authorized to specify by regulation an alternative list of age appropriate rights commensurate with this section.

(17) The patient shall have the right to have his or her pain assessed on a regular basis.

(18) Notwithstanding any other provisions of this section, upon request, patients receiving care through hospitals, nursing homes, assisted living residences and home health care providers, shall have the right to receive information concerning hospice care, including the benefits of hospice care, the cost, and how to enroll in hospice care.

History of Section.
(P.L. 1974, ch. 168, § 1; P.L. 1975, ch. 238, § 1; P.L. 1978, ch. 269, § 5; P.L. 1978, ch. 359, § 1; G.L. 1956, § 23-16-9.1; P.L. 1979, ch. 39, § 1; G.L. 1956, § 23-17-19.1; P.L. 1984, ch. 220, § 2; P.L. 1990, ch. 492, § 7; P.L. 1993, ch. 64, § 1; P.L. 1999, ch. 216, § 3; P.L. 1999, ch. 384, § 3; P.L. 2001, ch. 168, § 1; P.L. 2002, ch. 331, § 2; P.L. 2003, ch. 238, § 1; P.L. 2003, ch. 306, § 1; P.L. 2006, ch. 225, § 1; P.L. 2006, ch. 362, § 1.)

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PATIENT'S BILL OF RIGHTS

I have received a copy of the Patient's Bill of Rights and I am aware of its contents.

Signature: _____ Date:_____

Witness:_____ Date:_____

Child's Name:_____

Disclosure of Information

I acknowledge that by being present in the clinic during my child's treatment while another family is also being treated, I may acquire confidential information relating to that family. I agree that I will not directly or indirectly divulge or disclose for any purpose said confidential information that has been obtained by or disclosed to me as a result of this situation.

And, I also acknowledge that being present in the clinic while another family is working with another therapist may result in some of my or my child's confidential information being disclosed.

_____ _____

Parent/Guardian Date

_____ _____

Witness Date