easterseals
South Carolina

To learn more about our services, please scan the code below:

Welcome!

Thank you for choosing Easterseals South Carolina! We are proud to offer a full range of services including Early Intervention, Speech Therapy, Occupational Therapy, Physical Therapy, and Autism Services.

Our highly skilled and professional pediatric therapists are dedicated to helping your child reach their developmental goals. Our services are family focused and embrace parents and caregivers as the child's most important influences. As such, we request that parents and caregivers to be present and involved in all therapy activities. We also provide all of our services in your child's natural environment to build on the skills that they already use in their daily routines. This means that we will lean toward using items that are readily available to the child or already in the home so you can recreate the activities in between sessions so your child can practice new skills.

Please take a minute to review our welcome packet and complete the required paperwork. Your therapist will be more than happy to answer any questions that you might have.

Again, we thank you for choosing Easterseals and look forward to working with your family!

Commitment to Quality

Easterseals South Carolina is committed to providing high quality services to children and families! If you would like to provide feedback about your experience, please contact:

Melissa Griffin
Medical Rehabilitation Director
(803) 627-3857
mgriffin@sc.easterseals.com

Therapist Name:_____

Phone:_____ Email:_____

**When your child leaves our program, you will receive information for our Family Satisfaction Survey. Your feedback assists us in identifying our strengths as well as areas in which we can improve. We know that your time is precious; however, if you could take a few moments to complete the survey we would greatly appreciate it!

easterseals South Carolina

Policies for Medical Rehabilitation Services

Patient Rights:

As an Easter Seals patient, it is your right to:

- Be fully informed of Easterseals South Carolina policies
- Be treated with dignity and respect
- Receive the information necessary to give informed consent prior to the start of treatment
- Refuse treatment
- Receive timely responses to your questions or requests
- Receive treatment from skilled and qualified personnel

Parent/Guardian Responsibilities:

- Parent/Guardian must complete the Therapy Enrollment Packet at or prior to the initial visit. If your child is seen at daycare, please leave the signed copy on the day of your therapist's visit. Easterseals therapists will not be able to complete your first appointment if this paperwork is not available and/or signed prior to providing services.
- Parent/Guardian must notify Easterseals South Carolina of any changes in their child's primary care physician or contact information, including address, phone numbers, and/or caregivers.
- Parent/Guardian must notify Easterseals of any change in their insurance information, including status and policy numbers.
- It is the parent or guardian's responsibility to notify the therapist of necessary cancellations. Please provide as much notice as possible when notifying the therapist of cancellation. Many Easterseals therapists travel a long distance to reach their clients. Please be respectful of their time by letting them know as soon as possible when you need to cancel.
- Parent/Guardian must follow the Guidelines to Cancellations. Easterseals therapists work with medically fragile children and are cautious to prevent exposure to potentially dangerous illnesses.
- If a child is seen in the childcare setting, please contact your therapist in the event that the child will not be at childcare for a scheduled therapy session.

Attendance Policy

To ensure each patient gets the most benefit out of his/her therapy, consistency in attendance is very important. Patients are expected to participate in all scheduled appointments. If the patient arrives more than 15 minutes past the scheduled time, the therapist may not be able to treat that day, and the appointment would need to be rescheduled. Late arrivals where the patient is unable to be seen will be counted as no shows.

Loss of a set appointment time or discharge may occur under any of the following situations:

- Attendance is less than 75%
- The patient is consistently late for scheduled appointments
- Two consecutive appointments are missed
- Three or more appointments are cancelled in a month's time

It does become necessary from time to time to cancel your appointment due to therapist illness or absence. In these instances, the cancelled appointments will not be counted against the patient.

Patients seen on a follow-up basis (less than 2 times per month) will be discharged if the patient misses more than one appointment or no contact is received from patient within one month of missed appointment

Guidelines to Cancellations

Please contact your child's therapist to inform them if your child or any family member living in the home has any of the following symptoms:

- Communicable Disease-Chicken pox, fifths disease, hand/foot/mouth disease, measles, strep throat, flu, RSV, strep, stomach virus, etc.
- Fever over 100.4. Child should be fever free for at least 24 hours before resuming services
- Diarrhea
- Severe coughing
- Excessive drainage from the nose
- Conjunctivitis
- Sore throat
- Skin infections
- Vomiting
- Lice
- MRSA
- Scabies

*If bed bugs or fleas are present in your home, please contact your therapist to inform them of the situation. These are highly transferrable and could travel with the therapist infesting their home or the home of another child, therefore, until the home is free of these situations therapy sessions will need to occur in an alternate location.

Inclement Weather

Easterseals South Carolina staff members follow state government closings and delays. Therapists are asked to use their judgment in terms of whether or not it is safe to travel to your home. If inclement weather results in the need to cancel your appointment, the therapist will offer to reschedule the missed visit.

Easterseals South Carolina
Medical Rehabilitation Department

PO Box 5715 Columbia, SC 29715
(803) 627-3857
(803) 222-1518-Fax
www.sc.easterseals.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims 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 2*** *for more information on these rights and how to exercise them*

Your Choices

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

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *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 a copy of your health and claims records	• You can ask to see or get a copy of your health and claims 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 and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • 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 consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
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.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, 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'll 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. • We will make sure the person has this authority and can act for you before we take any action.
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, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing 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 payment for your care • Share information in a disaster relief situation *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

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.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

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.**

Help with public health and safety issues	• 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 abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you 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.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • 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
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

instruction C: Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides health plan members with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

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 or 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 than 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 this 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, on our web site, and we will mail a copy to you.

Instruction F: Insert Effective Date of Notice here.

This Notice of Privacy Practices applies to the following organizations.

Instruction G: If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.

easterseals
South Carolina

Consent for Treatment

Updated 7/11/16

I, undersigned, do hereby agree and give my consent for **Easterseals South Carolina** to furnish physical, occupational, and/or speech therapy services to_____, in order to diagnose and treat his/her development.

Medicaid/Related Programs and Private Insurance & Third Party Benefit Assignment Consent to Treat/Release Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicaid, private insurance, and third party payers to Easterseals South Carolina. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

I authorize and request that payment of Medicaid or other private insurance/ third party insurance benefits be made on my behalf to Easterseals South Carolina for any services provided to my child. I understand that for any period of time when my child is eligible for Medicaid or its related programs, Easterseals South Carolina may bill for those services provided and be paid directly by the Medicaid program. Easterseals South Carolina has permission to bill Medicaid retroactively for services performed prior to the date of this consent.

By signing this form, I also give Easterseals South Carolina permission to release or exchange medical or other confidential information as needed for treatment, payment, determination of benefits, processing of claims, and/or auditing of Medicaid benefits for those services.

Insurance Information

Does your child have private insurance coverage? ☐ Yes ☐ No
If yes:
Private Insurance Company:_____(Please include copy of card)
Policy Holder:_____ Policy #: _____

Does your child have secondary private insurance coverage? ☐ Yes ☐ No
If yes:
Secondary Insurance Company:_____(Please include copy of card)
Policy Holder:_____ Policy #: _____

Does your child have active South Carolina Medicaid coverage? ☐ Yes ☐ No
If yes, what type: ☐ Fee for Service ☐ MCO (Managed Care Organization) MCO Name:_____
Medicaid Number: _____

Is your child eligible for SC Part C (BabyNet) services? ☐ Yes ☐ No

I acknowledge that I am responsible for notifying Easterseals South Carolina of any changes in my child's insurance coverage.

_____ _____
Child's Name Child's DOB

_____ _____
Parent/Guardian Signature Date

easterseals
South Carolina

Authorization to Release and/or Obtain Information
Updated 7/11/16

This is an authorization for easterseals South Carolina to ☐ **RELEASE** and/or ☐ **OBTAIN** the following records regarding for the purpose of providing information to assist with evaluation, service plan development, treatment and/or other services for:

Child's Name: _____ **Child's DOB:** _____
Parent/Guardian Name: _____

Records should be released to/from:
Facility/Practice Name: _____
Facility/Practice Address: _____
Telephone#:_____ Fax #:_____ Email:_____

Records should be RETURNED to:
easterseals South Carolina
PO Box 84
Clover, SC 29710
Telephone #: (803) 627-0981 Fax #: (803) 701-9155 Email: medicalrehabilitation@sc.easterseals.com

Records to be released/obtained:
☐ All Records and Details
☐ Plan of Service/Care
☐ Records Establishing Diagnosis
☐ Records Relating to Functional Capacity
☐ Other (Please Specify below)
☐ Psychological Evaluation
☐ Medical Reports
☐ Treatment Records
☐ IEP

_____
_____

Patient rights and signature:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I understand that the information released in response to this authorization may be re-disclosed to other parties.
- I understand that a facsimile or copy of the authorization shall be treated as an original and that the original will be maintained in my case record.
- This authorization shall be in force and effect until discharge from easterseals medical rehabilitation services at which time this authorization expires unless I request a specific expiration date.
- I understand that the information in my records may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, HIV virus, AIDS or AIDS or AIDS related conditions.

_____
Print Name (Consumer/Legal Guardian)

_____ _____
Signature of Consumer/Legal Guardian **Date**

easterseals South Carolina

Therapy Registration Form

Updated 7/11/16

Patient Information: ☐ ST ☐ OT ☐ PT

Name:_____ Nickname: _____

☐ Male ☐ Female Date of Birth: _____ Social Security#:_____

Street Address/PO Box:_____

City:_____ State: _____ Zip Code: _____

Optional Patient Information:

Preferred Language: (drop down menu) Ethinicity: (drop down menu) Race: (drop down menu)

Parent/Guardian Information:

Name:_____ Relationship:_____

Check if same address as patient: ☐

Street Address/PO Box:_____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell:_____

Email address:_____

Is this child in DSS custody or Foster Care? ☐ Yes ☐ No

If yes, please completed DSS Caseworker information:

Name:_____ Phone:_____ Email:_____

Emergency Contact

Name:_____ Relationship:_____

Street Address/PO Box:_____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell:_____

Email address:_____

Do we have your authorization to contact this person regarding your therapy services if the need arises?

Important: Parent/Guardian must initial choice. Yes_____ No_____

Referring/Primary Care Physician

Physician's Name:_____ Practice Name:_____

Practice Address:_____

Practice Phone:_____ Practice Fax:_____

Email address:_____

Health and Developmental History

Medical Diagnosis/Reason for Referral:_____

Was your child: ☐ Full Term ☐ Premature If preterm, number weeks of gestation?_____

Pregnancy/Birth Complications? ☐ Yes ☐ No If yes, please describe:_____

_____

_____

List any current medications:_____

Allergies: ☐ Yes ☐ No If yes, please describe reaction:_____

Has your child had any hospitalizations or surgeries? ☐ Yes ☐ No If yes, please explain:_____

_____

Significant Medical History:_____

_____

_____

_____

_____

Do your child utilize any adaptive equipment or assistive technology in their daily routine? ☐Yes ☐No
If so, please provide details:_____

Please share any medical, developmental, or behavioral concerns that you have for your child:
_____
_____
_____
_____
_____

Has your child previously received therapy services from another provider? ☐Yes ☐No
If yes, what type? ☐OT ☐PT ☐ST Date of most recent evaluation:_____
Provider:_____

In signing this form, I agree that I have received and understand easterseals Policies for Medical Rehabilitation Services, including the Attendance Policy, and Guidelines for Cancellations.

I am also confirming that I have received the Notice of Privacy Practices. As required by HIPAA Federal Law, this notice explains how we plan to use and disclose your protected health information for the purposes of treatment, payment, and agency operations.I hereby verify that I have received and understand the Easter Seals Notice of Privacy Practices and agree to its terms. I am aware that the Notice of Privacy Practices may change and I may request a current copy by contacting easterseals or visiting the website at www.sc.easterseals.com.

_____ _____
Child's Name Date of Birth

_____ _____
Signature of Parent/Guardian Date

_____ _____
Therapist Date

GENERAL RELEASE FOR MINOR FOR USE OF PHOTOGRAPHY, VIDEO, AUDIO & SIMILAR

I, _____, the parent or legal guardian of _____, the minor for whom this Release is granted ("the minor"), hereby grant permission to Easter Seals South Carolina ("Easter Seals") to make photographs and video of the minor, still and moving, and to make audio recordings of the minor's voice. This permission is intended to include any and every means of photographing, video recording, or audio recording, whether the medium is film, tape, digital device, or other. Easter Seals may use the resulting photographs, slides, video, and voice recordings for any lawful purpose, including, but not necessarily limited to publishing on its website, in its brochures, flyers, and similar, publishing on Facebook, Twitter, Instagram, and other social media, publishing in Easter Seals national media, and in any other lawful medium, setting, or context whatsoever. I hereby represent and warrant that I have authority to provide this Release on behalf of the minor.

I understand and agree that the permission I am granting herein is **irrevocable**, meaning that once I grant this permission, neither I nor the minor, nor anyone else for the minor can revoke the permission for any reason, even if our relationship with Easter Seals ends. I agree that this Release and permission shall be binding on my and the minor's successors, heirs, representatives, assigns, beneficiaries, and all others. I understand that if Easter Seals chooses to use images and/or recordings of the minor as mentioned herein, then it would be practically impossible for Easter Seals to retrieve those images and recordings, once published. I grant this permission, therefore, with the full understanding that once published, Easter Seals will have no obligation to attempt to retrieve images and recordings of the minor, or to discontinue using them, even if I should later change my mind (or the minor should change his/her mind) about use of the minor's images and recordings.

I understand and agree that neither I nor the minor will receive any money or payment for granting this permission, either now nor in the future. However, I acknowledge that the minor and I have received valuable consideration from Easter Seals for granting this permission in other forms and ways.

I understand and agree that Easter Seals may use images and recordings of the minor in color, black and white, and images reproduced with clarity, distortion, or otherwise. Easter Seals may use the minor's real name, a fictitious name, or no name in conjunction with images and recordings of the minor. The minor and I waive any right to review, inspect, proof or edit images and recordings, and grant all such rights to Easter Seals. I hereby release Easter Seals and all Easter Seals employees, agents, representatives, parent and subsidiary companies, insurers and assigns, and all other people and entities whatsoever, from any demands, claims, damages and harm of any kind or nature whatsoever, whether discovered and advanced now or in the future, arising from or in any way connected with images and recordings of the minor. I agree to indemnify Easter Seals and hold Easter Seals harmless as to any demands, claims, damages and harm of any kind or nature whatsoever, whether discovered and advanced now or in the future, arising from or in way connected with images and recordings of the minor.

_____	_____	_____
Signature of Parent or Guardian	Date	Witness

OR, I hereby state my preference that Easter Seals *not* make and publish images and audio of the minor:

_____	_____	_____
Signature of Parent or Guardian	Date	Witness

GENERAL RELEASE
FOR USE OF
PHOTOGRAPHY, VIDEO, AUDIO & SIMILAR

I, _____, **hereby grant permission to Easter Seals South Carolina ("Easter Seals")** to make photographs and video of me, still and moving, and to make audio recordings of my voice. This permission is intended to include any and every means of photographing, video recording, or audio recording, whether the medium is film, tape, digital device, or other. Easter Seals may use the resulting photographs, slides, video, and voice recordings for any lawful purpose, including, but not necessarily limited to publishing on its website, in its brochures, flyers, and similar, publishing on Facebook, Twitter, Instagram, and other social media, publishing in Easter Seals national media, and in any other lawful medium, setting, or context whatsoever.

I understand and agree that the permission I am granting herein is **irrevocable**, meaning that once I grant this permission, I cannot revoke the permission for any reason, even if my relationship with Easter Seals ends. I agree that this Release and permission shall be binding on my successors, heirs, representatives, assigns, beneficiaries, and all others. I understand that if Easter Seals chooses to use images and/or recordings of me as mentioned herein, then it would be practically impossible for Easter Seals to retrieve those images and recordings, once published. I grant this permission, therefore, with the full understanding that once published, Easter Seals will have no obligation to attempt to retrieve images and recordings of me, or to discontinue using them, even if I should later change my mind about use of my images and recordings.

I understand and agree that I will not receive any money or payment for granting this permission, either now nor in the future. However, I acknowledge that I have received valuable consideration from Easter Seals for granting this permission in other forms and ways.

I understand and agree that Easter Seals may use images and recordings of me in color, black and white, and images reproduced with clarity, distortion, or otherwise. Easter Seals may use my name, a fictitious name, or no name in conjunction with images and recordings of me. I waive any right to review, inspect, proof or edit images and recordings, and grant all such rights to Easter Seals. I hereby release Easter Seals and all Easter Seals employees, agents, representatives, parent and subsidiary companies, insurers and assigns, and all other people and entities whatsoever, from any demands, claims, damages and harm of any kind or nature whatsoever, whether discovered and advanced now or in the future, arising from or in any way connected with images and recordings of me. I agree to indemnify Easter Seals and hold Easter Seals harmless as to any demands, claims, damages and harm of any kind or nature whatsoever, whether discovered and advanced now or in the future, arising from or in way connected with images and recordings of me.

_____	_____	_____
Signature	Date	Witness

OR, I hereby state my preference that Easter Seals *not* make and publish images and audio recordings of me:

_____	_____	_____
Signature	Date	Witness