MOSAIC Patient and Insurance Information

Bellevue Location
MOSAIC Children's Therapy Clinic
13010 N.E. 20th Street, Suite 300
Bellevue, Washington 98005
Phone (425) 644-6328
Fax: (425) 644-6295

Seattle Location
MOSAIC Children's Therapy Clinic
2111 N Northgate Way, Suite 101
Seattle, Washington 98133
Phone: (206) 388-3751
Fax: (206) 556-4515

Issaquah Location
MOSAIC Eastside Children's Therapy Clinic
1495 NW Gilman Boulevard, Suite 4
Issaquah, Washington 98027
Phone: (425) 392-2346
Fax: (425) 392-0185

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ ☐ M ☐ F
Last First M.I

Parent(s)/Caregiver/ Responsible Party	Phone Number(s) Home	Work	Cell	Email
Name:				
Name:				
Caregiver Contact Information:				☐ Please DO NOT include my email for MOSAIC's newsletters

Name

Address: _____ _____ _____
Street City Zip

Caregiver/ parents are: ☐ Married ☐ Separated ☐ Divorced Parenting Plan? ☐ Yes ☐ No (*Please provide copy of parenting plan if restrictions apply)*

Secondary Address: _____ _____ _____
Street City Zip

PHYSICIAN'S INFORMATION

Primary Physician: _____ Address: _____
Phone: _____

Referring Physician/Provider: _____ Address: _____
☐ *Same as above* Phone: _____

INSURED'S INFORMATION (PLEASE PROVIDE PRIMARY POLICY HOLDER INFORMATION)

Is your child covered under DSHS? ☐ Yes ☐ No Which DSHS coverage? ☐ Open Coupon ☐ Molina

Insured's Name: _____ D.O.B. _____ ☐ M ☐ F
Last First

Employer: _____ Member I.D: _____

Insurance Company: _____ Group I.D: _____

Insurance Address: _____ Effective Date: _____

_____ Insurance Phone #: _____

SECONDARY INSURANCE INFORMATION (PLEASE PROVIDE SECONDARY INSURANCE INFORMATION)

Does your child have DSHS as secondary insurance? ☐ Yes ☐ No Which DSHS coverage? ☐ Open Coupon ☐ Molina

Insured's Name: _____ D.O.B.: _____ ☐ M ☐ F
Last First

Employer: _____ Member I.D: _____

Insurance Company: _____ Group I.D: _____

Insurance Address: _____ Effective Date: _____

_____ Insurance Phone #: _____

Assignment and Release:
I hereby authorize MOSAIC Rehabilitation to release any information required by appropriate agencies or insurance companies. I understand that as a courtesy MOSAIC Rehabilitation has contacted my insurance company to see what Neurodevelopmental and Rehabilitation Benefits apply to my plan and I do not hold MOSAIC Rehabilitation responsible for the information received. I also authorize my insurance benefits to be paid directly to MOSAIC Rehabilitation and I am financially responsible for any unpaid balance.

I declare the foregoing information is true and correct.

_____ _____
Responsible Party Signature Date

_____ _____
Print Name (Responsible Party) Witness (to be signed by MOSAIC Staff Member)

☐ ☐

PATIENT HISTORY INFORMATION

Thank you for taking the time to fill out this form as completely and honestly as possible. Your input plays an important role in the evaluation process. All the information on this form is confidential and will not be released without your permission.

IDENTIFYING INFORMATION

Person Completing Form: _____ Relationship to Child: _____

Child's Name: _____ Date of Birth: _____ ☐ M ☐ F

Has there ever been a crisis plan developed? ☐ Yes ☐ No

If so, are you able to provide a copy to MOSAIC? ☐ Yes ☐ No

Are there any potential barriers to services at MOSAIC based on the child's age or culture, language, gender and physical condition? ☐ Yes ☐ No

FAMILY BACKGROUND

Mother's Name: _____ Age: _____ Father's Name: _____ Age: _____

Occupation: _____ Occupation: _____

Ethnic Background: ☐ White ☐ Black ☐ African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian ☐ Alaska Native ☐ Hispanic or Latino ☐ Combination of Races

Is this child: ☐ Your Biological Child ☐ Step Child ☐ Adopted Child ☐ Foster Child

If not your biological child, at what age did he/she come into your home:

Persons living in the home:

Language spoken in the home:

Does anyone related to this child have speech, psychological, learning or physical development problems or diagnosis? If yes, please describe: ☐ Yes ☐ No

BIRTH HISTORY

☐ *BIRTH HISTORY UNKNOWN*

Length of pregnancy with this child: _____ weeks

Did mother experience any of the following during pregnancy?

☐ Excessive Illness	☐ Flu	☐ Bleeding/Spotting
☐ Emotional Upsets	☐ Injury	☐ Rh Incompatibility
☐ Exposure to drugs/alcohol	☐ Marked Swelling of Hands/Feet	
☐ Exposure to trauma or abuse		

Condition of infant immediately after birth (check all that apply)

☐ Normal, no problems	☐ Breathing problems	☐ Birth Injury
☐ Difficulty with feeding, sucking, swallowing	☐ Jaundiced	☐ Congenital differences

Did any of the following occur during infancy? ☐ Does Not Apply

☐ Excessive crying	☐ Injury	☐ Other:
☐ Difficulty feeding/sucking/swallowing	☐ Breathing problems/ respiratory illness	

Please explain:

HEALTH / MEDICAL HISTORY

Developmental Diagnosis (e.g. autism, global developmental delay, etc.)	Medical Diagnoses:

Is your child is good health? ☐ Yes ☐ No

Is the child taking any medications? ☐ Yes ☐ No

If yes, please list prescribing physician, medication(s), dosage, and why used: (Example: Depakote for seizures)

☐ **NO KNOW MEDICATION OR FOOD ALLERGIES**

Please list any food or medication allergies:

Has the child seen the following specialists? (check all that apply)

☐ Psychologist
☐ Neurologist
☐ BCBA/ABA Therapist
☐ PT, OT, SLP
☐ Psychologist
☐ Psychiatrist
☐ Other _____

Please include names and phone numbers of specialist(s):

Explain reason child is seeing specialist(s):

Has the child ever had an operation or been hospitalized? ☐ Yes ☐ No

Dates/Surgery/Hospital: _____

Dates/Surgery/Hospital: _____

Any special needs or accommodations needed for treatment? ☐ Yes ☐ No

HEARING

Do you have concerns regarding your child's hearing? ☐ Yes ☐ No

Does your child have a history of frequent ear infections? ☐ Yes ☐ No

If yes, number of ear infections per year: _____

Has your child's hearing been tested? ☐ Yes ☐ No

When: _____

Where: _____

Results: _____

Does your child wear hearing aids, use an FM system or have a cochlear implant? ☐ Yes ☐ No

If yes, what kind?

VISION

Has your child's vision been tested? ☐ Yes ☐ No

When: _____

Where: _____

Results: _____

Does your child wear glasses? ☐ Yes ☐ No

Does your child have seizures? ☐ Yes ☐ No

If yes, please specify type and frequency:

DEVELOPMENTAL MILESTONES	SLEEPING
Please indicate the age at which your child began: _____ Social Smiles _____ Sitting _____ Walking _____ Talking	Does your child experience difficulty sleeping? ☐ Yes ☐ No If yes, please describe:

SENSORY PROCESSING

Do any of the following statements descript your child?

Expresses distress during grooming (for example, fights, cries during haircutting, washing face, fingernail cutting)	☐ Yes ☐ No
Fears heights	☐ Yes ☐ No
Seeks all kinds of movement and this interferes with daily routines (for example, can't sit still, fidgets)	☐ Yes ☐ No
Jumps from one activity to another so that it interferes with play	☐ Yes ☐ No
Is distracted or has trouble functioning if there is a lot of noise around	☐ Yes ☐ No
Poor endurance/tires easily	☐ Yes ☐ No
Responds negatively to unexpected or loud noises (for example, cries or hides at noise from vacuum cleaner, dog barking, hair dryer)	☐ Yes ☐ No
Watches everyone when they move around the room	☐ Yes ☐ No

ACADEMIC / THERAPY HISTORY

Does your child attend school? ☐ Yes ☐ Homeschool ☐ No Grade Level: _____

If yes, name the school: _____ School district: _____

Phone number: _____ Name of teacher: _____

Type of classes attended: _____ When did child begin school: _____

Student/Teacher Ratio: _____

Does your child receive the following services? (check all that apply)

Type of Therapy	School Therapist Name, Duration	Private Agency Name, Therapist Name, Duration
Example	*Mary Smith, 2x/week for 30 minutes*	*Anywhere Rehab, John Doe 1x/week for 60 minutes*
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Special Education		
ABA Services		
Other		

Evaluation / Therapy History

Previous Evaluation: ☐ Yes ☐ No Where: _____

School IEP: ☐ Yes ☐ No When: _____

Was an evaluation done?	☐ Yes	☐ No	When:
Did a licensed therapist do the evaluation?	☐ Yes	☐ No	
Was a re-evaluation done or scheduled?	☐ Yes	☐ No	When?

PSYCHOLOGY PARENT QUESTIONNAIRE

What is the primary reason for requesting this visit?

Please list any secondary concerns:

How would you describe your child's personality?

Do you have any behavioral concerns regarding your child? (please explain) ☐ Yes ☐ No

What, if any, behavioral strategies have been tried with your child? Please list both successful and unsuccessful strategies:

Successful:	Unsuccessful:

What do you feel are your child's biggest challenges/weaknesses?

Please provide information regarding the nature of any previous psychological/counseling services.

If the answer to any of the following questions is 'no' please provide some examples:

1. Does your child use appropriate attention seeking behaviors? ☐ Yes ☐ No
   (e.g.: tapping or using name, pointing to persons/objects (not grabbing or pulling towards object/person))

2. Does your child maintain appropriate eye contact? ☐ Yes ☐ No

3. Does your child follow verbal directions? ☐ Yes ☐ No

4. Is your child able to answer simple social questions (i.e.: name, age, address) ☐ Yes ☐ No

5. Is your child able to respond to simple 'wh' questions? ☐ Yes ☐ No
   (e.g.: What color is that ball? Where are your shoes?)

6. Does your child ask 'wh' questions for information? ☐ Yes ☐ No
   (e.g.: Who is that boy/girl?)

7. Does your child initiate a conversation around specific topic? ☐ Yes ☐ No
   (e.g.: trains, movies, baby dolls)

8. Does your child maintain appropriate proximity to conversation partners? (arm's length away) ☐ Yes ☐ No

9. Does your child pay attention to others nonverbal language and understand what is being communicated? (e.g.: hand signals, body language) ☐ Yes ☐ No

10. Does your child follow group routine/activities? ☐ Yes ☐ No

11. Does your child make transitions to the next activity when directed? ☐ Yes ☐ No

12. Does your child accept interruptions or unexpected changes? ☐ Yes ☐ No

13. Does your child respond to interactions from peers?
(e.g.: physically accept toys from peers, answers questions) ☐ Yes ☐ No

14. Does your child play cooperatively with peers?
(e.g.: roles during dramatic play, lead the play, games with rules?) ☐ Yes ☐ No

15. Does your child play with other children, such as sharing toys and talking about the play activities even though the play agenda of children by be different? ☐ Yes ☐ No

16. Does your child take turns during unstructured activities? (e.g.: pretend play, tossing a ball) ☐ Yes ☐ No

17. Does your child demonstrate aggressive behavior towards others? ☐ Yes ☐ No

18. Does your child have the ability to calm him/herself when upset? ☐ Yes ☐ No

19. Does your child have the ability to calm him/herself when their energy level is high? ☐ Yes ☐ No

20. Does your child use an acceptable way to express anger or frustration? ☐ Yes ☐ No

21. Does your child enjoy any hobbies or sports? ☐ Yes ☐ No

22. Please tell us the positive strengths and attributes you see in your child.

23. Please describe any other information that you feel may be pertinent to your child's care:

FAMILY HISTORY

Please check all that apply:

	Father	Mother	Brother	Sister	Grandmother	Grandfather	Other
Learning Difficulties							
Attention Difficulties							
Social Difficulties							
Behavior Difficulties							
Giftedness							
Depression or Anxiety							
Psychiatric Difficulties							
Suicide or Suicide Attempt							
Alcohol or Substance Abuse							
Criminal Activity							
Other							

Authorization / Consent for Release of Records

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2111 N Northgate Way, Suite 101
Seattle, Washington 98133
Phone: (206) 388-3751
Fax: (206) 556-4515

Child Full Name: _____ D.O.B.: _____

Parent(s) Name: _____

Purpose of Authorization for the release of records
As a parent or guardian you have the right to give permission or not give permission for the exchange of your child's records with other persons or agencies. This form provides you the opportunity to approve or not approve such a request.

List providers that may be contacted by MOSAIC for records & medical info
(Physicians, other therapy providers, schools, hospitals, etc.)

To:

NAME OF AGENCY/PERSON

Street Address

CITY, STATE, ZIP

Phone Number/Fax Number

From: MOSAIC Children's Therapy Clinic
13010 NE 20th Street, Suite 300
Bellevue, Washington 98004
(425) 644-6328 / Fax: (425) 644-6295

To:

NAME OF AGENCY/PERSON

Street Address

CITY, STATE, ZIP

Phone Number/Fax Number

Check all records types to be released

- ☐ Assessments/Reports/Evaluations
- ☐ Other: _____
- ☐ Other: _____
- ☐ Health/Medical Records
- ☐ Psychological/Counseling Records

The reason for disclosing the record(s) is:

- ☐ continuation of care/therapy
- ☐ other: _____

All information obtained will be kept private and used only for the planning of services or for billing for services provided from MOSAIC Rehabilitation.

Note: For release of medical records, the authorization will automatically expire 90 days from the date of signing.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent form release.

I declare the foregoing information is true and correct

Responsible Party Signature _____ Date _____

Print Name _____ Relationship to Child _____

Consent to use Photo Image

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MOSAIC Rehabilitation, Inc. may take photographs and/or videos of the Patient necessary for identification and/or medical purposes at any time during the Patient's Therapy Program. The Patient has the right to privacy. Photographs and/or videos cannot be used for any other purposes without the Patient's express written permission (signed Consent to Use Photo Image).

I understand that MOSAIC Rehabilitation, Inc. is undertaking initiatives to promote the clinic and its programs. I wish to assist in these efforts and herby grant MOSAIC permission as follows:

In signing the Consent, I understand and acknowledge that:

My child's photograph may be used by MOSAIC Children's Therapy Clinic in electronic communication productions and publication for instructional, informational, promotional or other purposes.

I have read this Consent to Use Photo Image in its entirety and understand it prior to executing it.

I hereby certify that I am the parent and/or guardian of (child(ren) name) _____,

The participant(s) named above, and ☐ DO ☐ DO NOT give my consent without reservations to the foregoing on behalf of him/her or them.

_____ _____

Responsible Party Signature | Date

_____ _____

Print Name | Witness / Date (to be signed by Mosaic Staff Member)

Insurance Waiver

(Signature required by all insured clients – if claims are or are not submitted)

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Name of Child: _____ D.O.B: _____

Insurance: _____

Name of Subscriber: _____

I understand that as a courtesy, MOSAIC Children's Therapy Clinic as contacted my insurance company to see what **Pyschological Services Benefits** apply to my plan.

Please note that BENEFITS QUOTED ARE NOT A GUARANTEE OF PAYMENT and may sometimes be misquoted over the phone. I DO NOT HOLD MOSAIC CHILDREN'S THERAPY CLINIC RESPONSIBLE FOR THE INFORMATION RECEIVED.

Due to the national coding laws, we MUST bill your insurance company the day of your child's visit and under the ICD-9 code provided by your physician. If your insurance does not cover some or all of these charges you will be billed directly for the balance they indicate as 'patient responsibility' when you receive your E.O.B. (Explanation of Benefits) from your insurance company. Please DO NOT ask us to re-bill your insurance by changing the procedure or diagnosis codes.

Final decision on benefits is determined when a claim is submitted and either paid or denied. The contract with the insurance company is between the company and me; MOSAIC Children's Therapy Clinic is not involved and does not accept responsibility for negotiation settlement of a disputed claim. In addition, we will not await payment/resolution from third party liability carries or from a carrier with whom MOSAIC Children's Therapy Clinic does not have a contract for the date of service.

I understand that my insurance company **may not** consider the psychological services provided by MOSAIC Children's Therapy Clinic to be a covered medical expense.

I understand that even when services are listed as being a covered medical expense on my insurance plan, payment is not guaranteed. Upon receipt of claims for services rendered, my insurance company will complete a review of medical necessity and based on that review (related specifically to my child) the services may not be considered to be medically necessary or may be considered as non-covered expenses and may not be paid by my insurance company.

I elect to have MOSAIC Children's Therapy Clinic to provide services for my child. I understand that if my insurance company does not allow benefits or approve payment of claims for services my child has received, I am responsible for all incurred charges and I agree to pay the balance in full. I hereby authorize payment from my insurance company directly to MOSAIC Children's Therapy Clinic for services provided.

- Insurance co-pays are due at the time of service.
- I understand that I am responsible for payment of my account on a timely basis, whether payments are made by me or by my insurance company.
- If claims are submitted to insurance and payment is not received within 45 days, I agree to follow up with the insurance company regarding payment and personally make regular payments to *MOSAIC Children's Therapy Clinic on* my account.
- All charges are due in full within 00 days from date of service unless a separate payment arrangement has been approved and signed by both *MOSAIC Children's Therapy Clinic* and myself.
- In the event that my insurance company denies payment, I am fully and directly responsible for the payment of all charges. My portion of the bill is due upon receipt of the statement.
- Patient balances unpaid over 90 days will be sent to collections.

_____ _____

Responsible Party Signature | Date

_____ _____

_____ _____

Print Name (Responsible Party) | Witness (to be signed by MOSAIC Staff Member)

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Non-covered Services Waiver

Client Name: _____

Your health insurance does not cover all of your health care costs. If an item or service is not considered a "covered benefit" under your health insurance plan, then your health insurance company will not pay for its costs.

We believe that the following services, although not covered by your health insurance, would be beneficial to you and we recommend these services as part of your treatment plan. If you decide to receive these services, then we will bill the cost directly to you, since your health insurance will not cover them. Please note that we must also bill you directly for costs associated with the provision of these services, including our travel time.

The purpose of this form is to allow you time to decide whether you wish to receive these services. We will render these services only after you have elected to receive them, as indicated by your signature below.

Over the course of treatment you may wish to have consultations with your clinician outside of your regularly scheduled treatment times. This may include:

- Email communications with family, other caregivers, schools etc.
- Phone call communication with family, physicians and care providers including attendance at IEP meetings. This also includes any travel time going to and from the meetings.
- Additional documentation requests which may include letters of medical necessity, progress reports, special reporting
- 1:1 meetings
- Other:

These services are billed at a rate of $200 per hour.

I acknowledge that I have been informed, in advance of receiving these services, that these services are not covered by my health insurance. I have chosen to receive these services and understand that I will be financially responsible for the charges as listed above.

Responsible Party: _____

Signature: _____

Date: _____

This authorization will remain in effect until revoked in writing by the responsible party.

Financial Agreement and Agreement to Treat

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FINANCIAL AGREEMENT

THIS AGREEMENT is entered into this _____ day of _____, by and between MOSAIC Rehabilitation, hereinafter referred to as the "Facility," and _____ (child's name), hereinafter referred to as "Patient," and _____ (parents name), hereinafter referred to as "Financial Responsible Person and/or Patient Representative."

PAYMENTS

Patient and Financial Responsible Person agree jointly and separately to assume and be liable for all charges of whatever nature incurred by or on behalf of Patient and to pay such charges as they become due.

Patient and Financial Responsible Person further agree that if the services rendered by Facility to Patient are covered by insurance, or benefits under either Title XVIII or Title XIX of the Medicare Act (Medicare/Medicaid), it is nevertheless the joint obligation of Patient or Financial Responsible Party to pay all charges incurred by or on behalf of Patient. Patient and Financial Responsible Person further agree that any co-insurance or deductible obligation under Medicare, Medicaid, or private insurance must be paid by Patient or Responsible Person.

- Patient responsibility is due upon receipt of insurance explanation of benefits (EOB). Because it is extremely impractical or difficult to ascertain all items of damage or amounts thereof which would be sustained by Facility as a result of an account becoming delinquent, Patient and Financial Responsible Person agree that any charges which are not paid in FULL when due shall be subject to a late fee. If balance remains unpaid 30 days after date of EOB a $35.00 late fee will be charged and account may be transferred to Transworld Systems Inc. Should Patient's account be referred to an attorney for collection, Patient and Financial Responsible Person agree to pay, in addition to all sums due, all reasonable attorney's fees, court costs, and all reasonable costs of collection.
- Patient certifies and warrants that all information submitted by him for purposes of applying for or receiving benefits under Title XVIII or Title XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Financial Responsible Person agree to indemnify and hold harmless Facility from and against any and all loss, damage, cost, expenses or liability resulting from Patient's submission of false or incorrect information to Facility. The Patient authorizes any health care facility or doctor to furnish to Facility and/or the Social Security Administration, its fiscal intermediaries or carrier all requested information from Patient's medical or financial records. Patient further authorizes Facility to disclose all or any part of Patient's medical or financial records to any person or entity which is or may be liable under contract to Facility, Patient, or to a family member or employer of Patient to pay all or a portion of the costs of care provided to Patient, including, but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carrier, welfare fund or Patient's employer. Patient further authorizes Facility to disclose all or any part of Patient's medical or financial records to any independent auditor of Facility. Patient requests that payment of authorized benefits be made to Facility on his behalf.
- **Facility does not make any assurance of any kind whatsoever that Patient's care will be covered by Medicare/Medicaid or private insurance companies, and the Patient and Financial Responsible Person hereby release Facility, its agents, servants and employees from any liability or responsibility in connection with the Patient's and/or Financial Responsible Person's potential claim of coverage under Medicare/Medicaid or insurance companies.**
- In this agreement, whenever the context so requires, the masculine gender includes the feminine and/or neutral and the singular number includes the plural.

AGREEMENT TO TREAT

PATIENT CARE

The Facility shall provide services and materials in compliance with the orders of Patient's attending physician. Administration of Therapy Treatments will be delivered as ordered by said physician.

- The Facility welcomes all person without regard to race, color, national origin, religion, sex, or qualified handicaps.
- The Facility shall provide services and materials in compliance with the orders of Patient's attending physician. Administration of treatments will be ordered by said physician.
- **Consent to Treatment:** Patient and Patient Representative acknowledge that Patient is under the medical treatment and care of said attending physician, and that the Facility renders its services to Patient under the general and specific instructions of said physician. Patient and Patient Representative recognize that said physician furnishing services to Patient is an independent Contractor and is not an employee or agent of Facility.
- **Restrictions and Liabilities:** The Facility shall incur no liability for injuries of any kind suffered by Patient while under its care, therefore should the Patient discontinue treatment before the attending physician has so ordered Patient, Patient and Patient. Representative agrees to assume all responsibility for all results which may follow.
- Facility is not liable for injury to Patient caused by visitors attempting to assist or treat Patient in any way. For the safety of Patient and others, only the Patient and Patient's guardian, if a minor, are permitted in Patient treatment areas.
- The Facility shall not be responsible for personal belongings left in the Facility.
- **The Clinic may take photographs and/or videos of the Patient necessary for identification and/or medical purposes at any time during the Patient's Therapy Program. The Patient has the right to privacy. Photographs and/or videos cannot be used for any other purposes without the Patient's express written permission (signed Consent to Use Photo Image).**
- In this agreement, whenever the context so requires, the masculine gender includes the feminine and/or neutral and the singular number includes the plural.

THE FINANCIAL RESPONSIBLE PERSON OR OTHER PERSON WHO SIGNS THIS AGREEMENT ON BEHALF OF AND IN THE PLACE OF THE PATIENT REPRESENTS THAT HE IS AUTHORIZED BY PATIENT TO DO SO, AND THE ABOVE NAMED PATIENT AND FINANCIAL RESPONSIBLE PERSON SIGNING THIS AGREEMENT AGREES BY SO SIGNING TO ACCEPT ALL OF THE TERMS HEREOF AND TO PERFORM ALL OBLIGATIONS HER UNDER. THERE ARE NO REPRESENTATIONS MADE BY FACILITY OR ANY OF ITS EMPLOYEES OR AGENTS OTHER THAT ARE SET FORTH IN THIS AGREEMENT.

THE PATIENT AND FINANCIAL RESPONSIBLE PERSON CERTIFY THAT EACH OF THEM HAS READ THIS AGREEMENT AND RECEIVED A COPY THEREOF AND UNDERSTAND AND AGREES TO ALL THE PROVISIONS IN THIS AGREEMENT.

Patient Name	Date
Responsible Party Signature	Witness / Date (to be signed by Mosaic Staff Member)

MOSAIC Rehabilitation, Inc.

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POLICES & PROCEDURES
Updated: September 2014

MOSAIC Children's Therapy Clinic would like to welcome you to our facility. We are pleased that you have chosen us to provide care to your child. The following is a summary of our policies. Please retain this information for future reference.

HOURS OF OPERATIONS:

The MOSAIC clinic in Bellevue is open Monday through Thursday 8:00am to 6:00pm, Friday from 8:00am to 5:00pm and Saturday from 8:00am to 5:00pm. The clinic in Seattle is only open Monday through Friday 8:00am to 6:00pm. The clinic in Issaquah will be open Monday through Friday 8:00am to 6:00pm and Saturdays by appointment.

MOSAIC is also closed on the following holidays: New Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day (other scheduled closures will be posted in the parent waiting area or on our website).

APPOINTMENTS:

Appointments are scheduled following the initial evaluation. Please check with the front desk after your child's initial evaluation to schedule on-going treatments. **(NOTE: Your child may or may not be scheduled with the therapist that has performed the initial evaluation).** Once scheduled, your child will be seen weekly at the same time unless otherwise specified by the therapist or administrative staff. If you need to change your child's ongoing treatment day and time please notify us as soon as possible. We will do our best to accommodate your needs but cannot guarantee your preferred day and time request. If we cannot meet your request, your child wills be placed on our wait list and will be notified if it becomes available.

_____
Initial

Wait List Procedure: We cannot guarantee a timeframe on when your preferred time will become available. Time slots are offered first to current patients on the therapy schedule. If we are unable to fill the time slot, calls are then placed to patients on our waitlist according to the date they were added on a first come, first serve basis.

ALLERGY AND/OR DIETARY CONCERNS:

If your child has allergies or dietary concerns, please notify the therapist and/or front desk so we may place a note on your child's chart. Because many children have allergies to animal dander, pets are not allowed in the clinic.

OBSERVATIONS:

You are welcome to observe your child's therapy session at any time. Please check with your therapist prior to the initiation of the treatment session. If you are not observing, you are welcome to wait in our waiting room area. If you need to leave the building for any reason, please make certain that your therapist and the front desk has a contact number where you can be reached in case of an emergency. **We ask that parents return 10 minutes prior to the end of the schedule session.** This will allow the therapist time to review your child's progress and answer any questions you may have. Parents are required to stay on the premises at all times if their child has a medical condition that requires specific medication or emergency care. Parents should never be more than 10 minutes away from the clinic (including drive time).

Other professionals are welcome to observe your child's therapy session. Please notify your child's therapist if you wish to set up an observation.

CLIENT REQUESTED SERVICES:

These services are provided by a MOSAIC team member and are not covered by insurance. These services may include parent meetings, meetings with other professionals, and observations at schools, travel time, telephone conversations, e-mails and reports. These non-covered services will be billed at the current hourly rate. A discount may be provided if payment is made at the time of service.

EDUCATIONAL CONSULTANT SERVICES:

These services are billed directly to the clients, the rates will be discussed with you at the time the services are requested.

OTHER CLINIC RULES:

Children must be supervised at all time while in the clinic space. It is the clinic policy that children who are not participating in therapy are not allowed in the gym or other treatment areas. Please supervise your children while they are in the waiting area.

ATTENDANCE:

In order for your child to receive the maximum benefit from therapy services, it is important that you attempt to keep all scheduled appointments. We understand that there may be times that attendance is not possible (illness, family emergency). However, ***your child must attend at least 80% of their scheduled therapy sessions over a three month period (10/12 sessions) or risk being removed from the schedule.*** Some insurance companies may deny all sessions if they show a pattern of poor attendance on the basis that the services are not medically necessary if missing sessions is not having a negative impact on the child. If you miss a scheduled appointment please work with the front office to schedule make up session on subsequent weeks. Please be mindful of this when scheduling vacations and other appointments. If your child is removed they will be placed on an on-call list, you may then call at the beginning of each week to schedule an appointment where a therapist has a cancellation on her schedule.

Initial _____

1. **Illness:**
   If you, your child or one of their siblings is sick or has a fever please do not bring them to the clinic. If your child has experienced vomiting, diarrhea or any infectious commutable conditions please make certain they have been symptom free for at least 24 hours before bringing them to the clinic or resuming therapy. Exception to the cancellation policy may be made in instances of emergency or illness.

Initial _____

2. **Cancellations:**
   In the event that your child is ill or if there is a family emergency, please call us as soon as you are able to do so. 'Late Cancellations' (cancellations LESS than 24 hours prior to the scheduled therapy visit) are costly to our office and will be assessed and a fee will be charged directly to the patient depending on the services that are missed. You are encouraged to reschedule your therapy appointments.

Initial _____

3. **Late Arrivals and Pick-up:**
   You must arrive timely for your child's therapy session. If your child's session is not able to start within 8 minutes of its scheduled start time you will be required to pay privately for the first 15 minutes of the session. Charges will apply for this time.

   If you will not be attending your child's therapy session, you must be in the lobby 10 minutes prior to the scheduled end time. We do not provide babysitting services. You will be charged our current billing rate for any late pickups.

Initial _____

4. **No Shows:**
   If you fail to keep a scheduled appointment and have not cancelled you will be charged a no-show fee. If your child is scheduled for more than one discipline on a given day, the cancellation and or no-show fee will apply to each scheduled appointment missed.

Please Note:

- Two 'No-Shows' and/or numerous 'Late Cancellations' and 'Late Arrivals and/or Pick-ups' will result in removal of your therapy time slot.
- Appointments missed more than 2 weeks in a row within a 3-month period (i.e. for vacations or other reasons) will result in loss of therapy time slot. If a patient will be gone more than 2 weeks in a row and you want to keep the spot/s, you can choose to cash pay for those visits you will miss in order to reserve your spot.
- Current rates and charges per discipline can be provided to you by the front desk.

It is not our intention to cause undue hardship; however we must collect our receivable as efficiently as possible in order to continue our service to the community.

INSURANCE VERIFICATION AND TRACKING:

Please provide proof of insurance prior to or at the time of your visit. MOSAIC will phone your insurance company to verify that your policy is in effect and to determine if there is a co-payment due at the time of service. Please remember that it is your responsibility to know what your insurance plan coverage is. We will call and verify benefits and do our best to track your visits; however it is ultimately your responsibility to know what is covered by your plan and any limitations.

1. **Co-Payments:**
   Your co-payments are due at the time of service. It is your responsibility to check in and make payment at every visit. We understand that at times the front lobby can be very busy and you may have to wait in order to accomplish this. **If your co-payment is not made at time of service and we need to bill you we will charge a billing fee of $10.00 per visit.**
2. **Co-Insurance:**
   Most insurance plans carry a co-insurance. Upon receipt of your first insurance explanation of benefits if you have a co-insurance we will begin to collect that amount from you at the time of service also.
3. **Deductible:**
   Deductible payments are to be paid at the time of service until the balance has been met.

I acknowledge receipt of MOSAIC Children's Therapy Clinics Policies and Procedures.

Patient Name

Responsible Party Signature | Date

Print Name | Witness / Date (to be signed by Mosaic Staff Member)

Copies: 1- patient chart 2- parent (s)

Please refer to the Parent Handbook regarding any other information.

Notice of Privacy Practice

Effective: October, 2014

Bellevue Location
13010 N.E. 20th St, Suite 300
Bellevue, Washington 98005
Phone: (425) 644-6328
Fax: (425) 644-6295

Seattle Location
2111 N Northgate Way, Suite 101
Seattle, Washington 98133
Phone: (206) 388-3751
Fax: (206) 556-4515

Issaquah Location
1495 NW Gilman Blvd, Suite 4
Issaquah, Washington 98027
Phone: (425) 392-2346
Fax: (425) 392-0185

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.

This Notice serves as a notice for MOSAIC Rehabilitation. We will follow the terms of this Notice and may share health information with each other for purposes of treatment, payment and health care operations as described in this Notice and as required under the Health Insurance Portability and Accountability Act of 1996. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective March 26, 2013. It applies to all protected health information (PHI) as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit MOSAIC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Assess and continually work to improve the care we render and the outcomes we achieve.
- Communicate with other providers who contribute to your care.
- Comply with state and federal laws that require us to disclose your PHI.
- Plan your care and treatment.
- Receive payment from you, your plan, or your health insurer.
- Serve as a legal document.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of MOSAIC, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. MOSAIC maintains an electronic medical record ("EMR"). You have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. MOSAIC Rehabilitation may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. MOSAIC is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for MOSAIC; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by MOSAIC, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Obtain a written accounting of certain non-routine disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. If we maintain your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request. You must submit your request in writing to the Privacy Officer. The first list you request within a 12-month period is free of charge, but MOSAIC may charge you for additional lists within the same 12-month period. MOSAIC will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Place a restriction to certain uses and disclosures of your information. In most cases MOSAIC is not required to agree to these additional restrictions, but if MOSAIC does, MOSAIC will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). MOSAIC must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities

MOSAIC is required to:

- Abide by the terms of the Notice currently in effect
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Maintain the privacy of your PHI.
- Notify you in writing if we are unable to agree to a requested restriction.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.
We will not use or disclose your PHI without your written authorization, except as described in this Notice.

How We Will Use or Disclose Your Health Information

1) *As Required by Law*: We may use or disclose your PHI if we are required by law.
2) *Communication from Offices*: We may call your home or other designated location and leave a message on voice mail, in reference to any items that assist MOSAIC in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist MOSAIC in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.
3) *Communication with Family/Personal Friends*: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.
4) *Coroners, Medical Examiners and Funeral Director*: In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

5) *Deceased Individuals*: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.
6) *Food and Drug Administration (FDA)*: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
7) *Fund Raising*: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at MOSAIC, to a business associate or a foundation related to MOSAIC so that they may contact you to raise money for MOSAIC. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.
8) *Health Care Operations*: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide. Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, MOSAIC that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.
9) *Health Oversight Activities*: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.
10) *Inmates and Correctional Institutions*: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.
11) *Law Enforcement*: We may disclose PHI for law enforcement purposes as required by law.
12) *Lawsuits and Disputes*: We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.
13) *Marketing*: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.
14) *Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
15) *Open Treatment Areas*: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.
16) *Organ Procurement Organizations*: Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
17) *Payment*: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.
18) *Public Health*: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
19) *Research*: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. MOSAIC may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.
20) *Sale of PHI*: MOSAIC may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.
21) *To Avert a Serious Threat to Health or Safety*: We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.
22) *Treatment*: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, MOSAIC operates an EMR. This is an electronic system that keeps PHI about you. MOSAIC may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. MOSAIC may also disclose PHI about you to, and obtain your PHI from, electronic PHI networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself. MOSAIC may use a prescription hub which provides electronic access to your medication history. This will assist MOSAIC health care providers in understanding what other medications may have been prescribed for you by other providers.
23) *Workers Compensation*: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact:

Andrea Duffield
MOSAIC Rehabilitation, Inc.
13010 NE 20th Street, Suite 100
Bellevue, WA 98005
425-644-6328

If you believe your privacy rights have been violated, you can file a written complaint with MOSAIC's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights

YOU WILL NOT BE PENALIZED OR RETALIATED AGAINST FOR FILING A COMPLAINT

Print Name **Date**

Responsible Party Signature

Counselor Disclosure Statement

WA State Administrative Code requires the disclosure of the following information in written form by counselors to their clients.

Lionel Enns
Child Psychologist
PY 60332197

MOSAIC Rehabilitation, Inc.
13010 NE 20th Street Suite 100
Bellevue, WA 98005

MOSAIC Rehabilitation, Inc.
4909 25th Ave NE Suite 200
Seattle WA, 98105

Disclosure Statement

This is a statement of your rights and responsibilities for our therapeutic relationship. The RCW 18.19.060 and WAC 246-810-031 require counselors to provide written disclosure of the following information to clients before counseling begins. Please read this statement thoroughly and then sign the consent for treatment on the reverse side. If you have any questions or concerns, please tell me and I will be happy to discuss them with you.

Client's Rights and Responsibilities

*Clients have the right to choose a counselor who best suits their needs and purposes.
*Clients may ask questions about treatment including costs, billing practices, medical record maintenance, matters of confidentiality, privacy and release of information at any time.
*Clients may choose to terminate therapy at any time.
*Clients have the right to be treated with respect and dignity, especially in regard to age, color, disability, ethnicity, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Qualifications/Education

Doctor of Philosophy, School Psychology, University of Washington, Seattle 2012

Clinical Focus

My work is divided between assessment and treatment of psychological and developmental disorders. The age range of the children I work with is quite broad, from 14-month-old toddlers to young adults.

Sample:

My work integrates many different therapeutic styles and techniques depending on what fits best with the client and situation. My main focus tends to be behavioral in that I think that most challenging behaviors with children should be targeted via parenting and the overall environment. I also work with many children via cognitive behavior therapy. I focus on clients' strengths and help them find solutions that can be maintained over time.

Confidentiality

Clients can rely on me to maintain confidentiality regarding our work together with these few exceptions:

1) I may consult with other therapists, who are required to keep client information confidential, for case consultation purposes.
2) Washington State Law requires that suspected abuse or neglect of a child, dependent adult, or developmentally disabled person be reported.
3) Washington State Law also requires that others be informed if a client threatens to harm herself/himself, or others. If that threat is perceived to be serious, the proper individuals must be contacted: this may include the individual against whom the threat is made.

4) In the event of a court order, counselors may be required to disclose information in the presence of a judge.
5) Information which may jeopardize my safety will not be kept confidential.
6) In the event of a medical emergency, emergency personnel may be given necessary information.
7) If you bring a complaint against me with the State of Washington, Department of Health, information will be released.
8) In the event of the client's death or disability, the information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.

Regarding Court Requirements
It is my policy NOT to provide clinical evaluations or assessments of the quality of client participation when clients are accessing counseling to fulfill court requirements or for other legal purposes.

A treatment plan will be developed with your agreement.

I can be reached at (425) 644-6328 (Bellevue Clinic) or (206) 388-3751. I will return your call as soon as possible. If you are experiencing an emergency situation, please call 911, or the Crisis Line at [Snohomish County (425) 258-4357], [King County (206) 461-3222], or go to the nearest hospital emergency room.

Consent for Treatment
Disclaimer by the State of Washington: "Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for the protection of public health and safety. Registration does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment."

With my signature, I acknowledge that I have read and understand this disclosure and the accompanying counseling information sheets. I consent to therapy with LIONEL ENNS, CHILD PSYCHOLOGIST, according to the terms described here.

_____	_____
Client Name(s)	Therapist Signature
_____	_____
Client Signature	Client Signature
_____	_____
Parent/Guardian Signature	Date