Music Therapy Services of Portland
Clinic: 9517 SW Barbur Blvd., Portland, OR 97219
Mailing: 14726 Albers Way NE, Aurora, OR 97002
Phone: 971-221-7144
www.musictherapyportland.com

The entire staff at Music Therapy Services of Portland would like to thank you for choosing us and welcome you to our family. It is our goal at Music Therapy Services of Portland to provide you with outstanding services, support, and communication regarding your family's needs. We provide an environment that is encouraging, well-informed, enjoyable, and sincere. We want you to be an integral and active participant in your child's therapy and learn how to provide an environment for your child and family that will support his/her development. We also want you to be involved in establishing goals, treatment planning, home exercises, and discharge planning. Our intention is to move towards a level of independence within everyone's abilities.

Included in our paperwork you will find:
- ☐ family/patient information sheet
- ☐ financial agreement/attendance policy
- ☐ consent to treat/medical release/permission for exchange of information
- ☐ permission to leave site
- ☐ Audiovisual release
- ☐ HIPAA policy

Please read all forms thoroughly so that you are informed about the agreements you are signing, and ask any questions to better help us serve you and your family.

Additionally, some other pieces of information are requested:
- ☐ Copy of driver's license.
- ☐ Copy of the front and back of your insurance card
- ☐ Current prescription from PCP – Must state MT services 1x a week, for 12 months for specific diagnoses (We can help you with this. Just give us a call and we'll draft a request.)
- ☐ Most recent OT/ST/PT/Psychological evaluations within the past year
- ☐ Waiver and/or Grant information (if applicable to your child)

Please note that these items must be received prior to your child's initial evaluation. If they are not received prior to your first appointment, we ask that you arrive 30 minutes early in order to complete your paperwork. We look forward to working with your family.

Thank you,
Angie Kopshy, MM, MT-BC
Owner of Music Therapy Services of Portland

Patient Information Form

Patient's Name (as appears on insurance card): _____ DOB:_____

Male / Female Parents' Names: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Cell Phone Number: _____

E-mail: _____ *Please circle preferred method of communication.

Diagnosis (if known): _____

Primary Physician: _____

Physician's Phone and Address:_____

Other doctors and specialists who is involved in your child's care:

Name	Specialty	Phone #

How did you hear about Music Therapy Services of Portland? _____

Insurance Information:

Primary Insurance: _____ Name of Insured: _____

Insured SS #: _____ Insured's D.O.B: _____Employer's Name:_____

Member ID: _____ Group #: _____

Claims Address (found on back of card): _____

Customer Service Phone #: _____

I understand and agree to the Music Therapy Services of Portland Notice of Privacy Practice.

Signature: _____ Date: _____

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Family Background

Mother's Name:_____ Age:_____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Marital Status: __Single ___Married __Divorced __Separated __Widowed Is your child adopted? ___Yes ___No

Languages Spoken at Home (circle primary): _____

Brother(s) and/or Sister(s) of the child:

Name	Age

What are your priorities in coming to Music Therapy Services of Portland?_____

_____

_____

_____

Does your child currently receive other therapy services? ___ Yes ___No

If "Yes", where and when? _____

_____

Medical History

At how many weeks was your child born? _____ Birth weight? _____

Were there any complications during the pregnancy or delivery? ____Yes ____No Please describe: _____

_____

Was your child hospitalized after birth? _____

Does your child have any other medial issues? _____

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Please list any hospitalizations and/or medical procedures your child has received: _____

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies? ___ Yes ___ No. If yes, please describe: _____

_____

Any diet restrictions? ___ Yes ___ No. If yes, please describe: _____

Education Information

Is your child currently enrolled in school? ___ Yes ___ No

If "Yes", where and days attended: _____

Does your child receive any services through the school? ___ Yes ___ No

If "Yes", what services? _____

Does your child have a current Individualized Education Plan (IEP)? ___ Yes ___ No

Social/Emotional History

What are your child's favorite toys/activities?_____

What are your child's favorite songs? _____

What typically calms/soothes your child? _____

Is your child currently enrolled in any community activities (music class, play groups, gymnastics, Aquatic

Lessons)? _____

Anything else you would like to tell us about your or family? _____

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

PRINTED NAME RELATIONSHIP TO CHILD

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PERMISSION FOR EXCHANGE OF INFORMATION

I authorize Music Therapy Services of Portland to release necessary and pertinent medical information to physicians, case managers, and insurance companies as needed for my child, _____.

Approved information may be exchanged with the following people directly related to my child's care:

___ Other Therapists

___ School Name: _____

___ Please list any others: _____

Approved information includes written documents and/or verbal discussion.

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

PRINTED NAME

PERMISSION FOR PARENT TO LEAVE SITE DURING TREATMENT

I _____ (Parent or Legal Guardian) acknowledge that I am the parent of _____ . I understand that while my child is receiving therapy I may leave the premises. However, I will give Music Therapy Services of Portland a working cell phone number where I can be reached during my absence. In addition, I agree that I will return prior to the end of the end of the session. I give consent and permission to Music Therapy Services of Portland for any additional treatment or transportation that may be needed in the event that my child is injured or needs medical attention. Also, I understand that the ability to continue to leave the premises while my child is at therapy is at the discretion of Music Therapy Services of Portland and/or my child's therapist.

I hereby release Music Therapy Services of Portland and any agents or assignees, from any and all claims for damages related to my leaving the premises during my child's therapy.

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

PRINTED NAME CELL PHONE # SECONDARY EMERGENCY CONTACT PHONE #

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CHILD'S NAME:_____ DATE OF BIRTH: _____

FINANCIAL AND INSURANCE POLICY

A copy of your driver's license and insurance information is required before services begin. Benefits will be verified upon receipt of your insurance information and you will be made aware of any **estimated** out-of-pocket expenses before any services are started. Information obtained from insurance companies is **not always a guarantee** of payment. Families are ultimately responsible for payment for non-covered services. **It is imperative that families are aware of their insurance coverage and their potential responsibilities.** We will strive to keep open communication in regards to insurance and payment. Families will inform Music Therapy Services of Portland of any changes regarding insurance. Families assign benefits for filed claims to be paid to Music Therapy Services of Portland. Any payment sent directly to the family, intended to cover therapy services provided by Music Therapy Services of Portland, should be given to the front office. _____ parent initials

The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, the **full amount applied to your deductible will be billed to you**. Music Therapy Services of Portland does not currently accept Medicaid, therefore families are responsible for all co-pays, coinsurances, and deductible expenses associated with each date of service. Please contact us directly if you are experiencing financial hardship. Music Therapy Services of Portland accepts cash, check, debit, VISA, MASTERCARD, Discover, and American Express. There is a $50 fee for all returned checks. _____ parent initials

We submit claims to insurance within one month of service dates. If payment has not been received within 60 days, the family will be responsible for the balance. If insurance makes payment, the family will be reimbursed any money that was paid for these services. If a family receives a bill that is not paid within 30 days of receipt of invoice, there will be a $20.00 late fee added, and services risk being put on hold. _____ parent initials

Music Therapy Services of Portland will file all insurance claims as an out-of-network provider. Deeming Waiver and SSI Medicaid are not accepted. We are not contracted with CMO plans (Amerigroup, Peachstate, or Wellcare). If authorization is required, therapists will submit based on need. Services will be administered after approval has been obtained. Music Therapy Services of Portland shall attempt OHP reimbursement; however, pre-authorization must be approved. _____ parent initials

An initial evaluation for music therapy services is $110/hour. Evaluations are an out-of-pocket expense expected at the time of service. An initial evaluation will be needed for all children starting therapy with our facility. Most evaluations will last 1 hour. If a family needs a re-evaluation for insurance or personal reasons, the rate will be $110/hr. Financial arrangements will be made prior to the time of evaluation. _____ parent initials

CONSENT TO TREAT

I, _____ consent for Music Therapy Services of Portland to provide my child, _____, with Music Therapy services. I consent to care and treatment falling under the practice guideline of the American Music Therapy Association (AMTA), and the State of Oregon. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

PARENT/GUARDIAN SIGNATURE DATE

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CHILD'S NAME:_____ DATE OF BIRTH: _____

ATTENDANCE POLICY:

Because of frequent no-shows and cancellations, Music Therapy Services of Portland policy states that we require a 24 hour notice for cancellations. After a one-time occurrence, a $40 fee will be charged for EACH missed therapy appointment. We know that sickness occurs; therefore, if you think that your child is sick the night before, please call us and give us notice so we may plan accordingly, and/or contact a family who is on stand by for a make-up session or on a waiting list for an evaluation or services.

To that end, we require that a current credit card be placed on file at all times. We will run the no-show/last minute cancellation fee on the date of expected service. This ensures that our clinicians will still receive payment in full for their time and service in preparation for the missed therapy session. In the event of a cancellation, we will make every effort to reschedule as we want your child to benefit from his/her therapy. If your child misses 3 consecutive weeks of therapy, we will make every attempt to hold that slot, but cannot guarantee this with an extended absence.

The staff at Music Therapy Services of Portland strives to meet the scheduling needs of every family. If your therapy time does not work for you, please let us know.

The Board of Health considers the following signs to indicate communicable disease/illness: Vomiting, Fever over 100 degrees, Diarrhea, Sore throat, Rash/Swelling, Red, or Running eyes. Please be sure your child is symptom free for 24 hours before resuming therapy. Please note that if you bring your child to therapy and he/she exhibits any of the above symptoms, it is at the therapist's discretion to send them home in order to protect themselves and our other clients from infectious illness.

PARENT/GUARDIAN SIGNATURE DATE

PRINTED NAME

CREDIT CARD AUTHORIZATION:

I authorize Music Therapy Services of Portland to maintain my credit/debit card on file. I understand that my card will only be used if: (a) My account has been delinquent for more than 90 days and I have not made any effort to make payment arrangements and/or (b) My appointment is cancelled with less than 24 hours notice or a "no show" occurs for a scheduled appointment. The fee for a late cancellation and/or no show is $40 for each missed appointment.

Credit Card Number: _____ Expiration Date: _____ 3-digit Security Code: _____

Name on Card: _____ Phone: _____

Cardholder's Address:_____

CARDHOLDER SIGNATURE DATE

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CONSENT FOR AUDIO/VISUAL RELEASE

I _____ (Parent or Legal Guardian) give permission for _____ (Name of Child) to be audio or video taped by the therapists at Music Therapy Services of Portland. These audio or video taped sessions will be used for education and training purposes only (i.e., clinical supervision, conference presentations). At no time will your child's full name be spoken on the tapes and your child's full identity will remain confidential. These tapes may be maintained in a locked facility.

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

PRINTED NAME

CONSENT FOR PHOTOGRAPH RELEASE

I _____ (Parent or Legal Guardian) give permission for _____ (Name of Child) to be photographed by the therapists at Music Therapy Services of Portland. These photographs will be used for education and training purposes (i.e., clinical supervision, conference presentations), and may be used by Music Therapy Services of Portland for advertisement purposes (i.e., brochures, newspapers).

☐ I do not consent to this photo release.

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

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Music Therapy Services of Portland

Notice of privacy practices
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:
How we may use and disclose your IIHI
Your privacy rights in your IIHI
Our obligations concerning the use and disclosure of your IIHI
The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002.
C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS
D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    i. Reporting child abuse or neglect
    ii. Preventing or controlling injury or disability
    iii. Notifying individuals if a product or device they may be using has been recalled
    iv. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. Our relationship with you does not confer any doctor/patient or similar privilege against disclosure.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

i. Regarding a crime violation in certain situations, if we are unable to obtain the person's agreement
ii. Concerning a death we believe has resulted from criminal conduct
iii. Regarding criminal conduct at our office or at the individuals residence during the treatment
iv. In response to a warrant, summons, court order, subpoena or similar legal process
v. To identify/locate a suspect, material witness, fugitive or missing person
vi. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI if requested by a government official.

6. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (ii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researchers agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities).

9. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals

11. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

12. Parent or legal guardian or other disclosed person. We may disclose information to any other parent or legal guardian of the patient, or to the following person(s) who you are specifically designating to receive this information:

13. Any other person or organization who you may authorize us to provide information to, if that authorization is in writing and is dated and signed by you.

14. Your primary care and/or your referring physician.

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The following categories describe the different ways in which we may use and disclose your IIHI

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have additional tests such as MRI, and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write an evaluation or we may disclose your IIHI to an Occupational Therapist (OT), Speech Language Pathologist (SLP), or Physical Therapist (PT) if requested. Many of the people who work for our practice – including, but not limited to, our OTs, PTs, and SLPs – may use or disclose your IIHI in order to treat you or to assist others in your treatment, Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Business Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Health-Related benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

6. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter be with the child during treatment. In this example, the babysitter may have access to this child's information.

7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

E. YOUR RIGHTS REGARDING YOUR IIHI
You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002. Your request must describe in a clear and concise fashion:
The information you wish restricted:
Whether you are requesting to limit our practice's use, disclosure, or both; and to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request in writing and submitted to Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, an MT sharing information with another MT in the practice; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before November 1st, 2006. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice or privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Music Therapy Services of Portland, 14726 Albers Way NE, Aurora, OR 97002. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact The Music Therapy Services of Portland,
14726 Albers Way NE, Aurora, OR 97002.

Effective Date of this notice: April 1st , 2010

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