Developmental Therapy Associates
& Absolute Speech and Language Therapy

3624 Shannon Rd. Suite 104
Durham, NC 27707
Phone: 919-493-7002
Fax: 919-403-1407

875 Walnut St. Suite 100
Cary, NC 27511
Phone: 919-465-3966
Fax: 919-465-3886

186 Wind Chime Ct. Suite 104
Raleigh, NC 27615
Phone: 919-870-1280
Fax: 919-870-1285

Acknowledgement

I acknowledge that I have received a copy of Developmental Therapy Associates, Inc. HIPAA Notice of Privacy Practices.

_____ DOB: _____
Client Name (Please Print)

_____ DATE: _____
Parent, Guardian, or Client Signature

Legal Authority to sign for this patient:
☐ Healthcare Agent ☐ Guardian ☐ Attorney in Fact ☐ Parent ☐ Next of Kin ☐ Administrator/Executor
If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact, or the administrator/executor of the patient's estate, you must provide appropriate documentation of the legal authority before records may be released.

Patient is: ☐ Minor ☐ Disabled ☐ Incompetent ☐ Incapacitated

Please Note: It is your right to refuse to sign this Acknowledgement.

Front Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ *An emergency prevented us from obtaining acknowledgment.*
___ *A communication barrier prevent us from obtaining acknowledgment.*
___ *The individual was unwilling to sign.*

*Other:*_____

*Staff Member Signature:*_____ *Date:*_____

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CONSENT FOR DISCLOUSRE OF HEALTH INFORMATION

Client Name: _____ DOB: _____

Address: _____

E-Mail: _____ Phone Number: _____

The purpose of this Consent for Disclosure of Health Information is to further define to whom client's Health Information can be disclosed:

Please Initial

☐ I authorize Developmental Therapy Associates, Inc. to mail me upcoming events postcard, brochures, etc.

☐ I authorize Developmental Therapy Associates, Inc. to email or text me information about therapy appointments, treatment documentation, etc.

☐ I authorize Developmental Therapy Associates, Inc. to call my home, work, or cell phone number and leave messages about upcoming appointments if I am not available to answer phone. (*No treatment message will ever be mentioned-just appointment time and date)*

☐ I authorize Developmental Therapy Associates, Inc. to email, fax or mail my therapy notes, plans of care, and evaluations to referring professional if requested.

Listed below are persons and their relationship to me with whom Health Information may be shared or discussed.

Name _____ Name _____

Relationship _____ Relationship _____
Phone Number _____ Phone Number _____
Fax Number: _____ Fax Number _____

Signature: _____ Date: _____

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Client Privacy Policy & Procedure Statement

Client Name: _____ Date of Birth: _____

Developmental Therapy Associate, Inc. maintains with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

DTA obtains your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality of care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical records by signing a letter for release of your medical information. DTA will provide one (1) copy of the client's evaluation and plan of care at no charge at the time the report was written. For additional requests for a copy of your medical records, there will be a charge of $.51 per page. If records are to be mailed per your request, postage will also be included.

We protect all client information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our organization manages client information, please contact the Privacy Officer at 919-465-3966.

Developmental Therapy Associates, Inc. reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations and guidelines. Notice will be provided.

By signing the following document, you indicate that you have read the Developmental Therapy Associates, Inc. Privacy Policy and Procedure Statement.

Signature: _____ Date: _____

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Consent for DTA to share Documentation with Physician

Dear Parent or Guardian:

A physician's referral is required by some insurance companies for a client to receive therapy services. When the evaluation or the initial treatment plan is completed, DTA will forward the report to the physician. For some clients, sharing the evaluation report is not a requirement. Please initial **one** of the following sentences below:

☐ I am aware that a copy of the evaluation report or initial treatment plan will be sent to _____ (client's name) physician.

☐ I do not want a copy of _____ (client's name) evaluation report or initial treatment plan sent to the physician.

Signature: _____ Date: _____

Legal Authority to sign for this patient:

☐ Healthcare Agent ☐ Guardian ☐ Attorney in Fact ☐ Parent ☐ Next of Kin ☐ Administrator/Executor

If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact, or the administrator/executor of the patient's estate, you must provide appropriate documentation of the legal authority before records may be released.

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