BLOSSOM
THERAPEUTICS

Blossom Therapeutics, LLC
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CONFIDENTIAL PERSONAL HISTORY

Today's Date:	Completed By:	
Child's Name:	Birthdate:	Age:
Parent A's Name:	Parent B's Name:	
Email:	Email:	
Phone:	Phone:	
Occupation:	Occupation:	
Primary Address:		
Primary persons, ages and relationships in home with child:		
Emergency Contact and # outside of home (not a parent):		
School:	Grade:	
Teacher's Name:	Type of Classroom:	
Teacher's Contact info:		
Primary Health Care Provider(s):		
A) Name:	Profession:	
Phone:	Address:	
B) Name:	Profession:	
Phone:	Address:	

Any medical precautions:

PERSONALITY PROFILE:

What are your child's gifts and strengths?

What do you enjoy most about your child?

What are your child's primary interests and hobbies?

How is your child functioning in school?

Does he/she need regular intervention to attend?

- 504-for what needs?
- IEP-for what needs?

What are her/his strengths and weakness in school?

PERSONALITY PROFILE:
What are your primary concerns regarding your child? What are the behaviors your seek help for or better understanding in order of priority (please be specific)?
What are the hardest times of day and why?
In what ways have you had to accommodate for your child's individual differences? Do you avoid certain situations at home, school or in the community?

GENERAL INFORMATION		
Any complications, illnesses or stress during pregnancy?	NO	YES, please explain
Any complications during labor and delivery?	NO	YES, please explain
How was your child delivered?		
What was the gestational age of your child at birth?		
What was your child's birth weight?		
What is your child's birth order?		
Your child's siblings (names and ages)?		

GENERAL INFORMATION		
Has your child received OT in the past?	NO	YES, please explain (duration, age, location)
Has your child received any OT, PT, and/or Speech in the current year?	NO	YES, from whom: How many visits this calendar year?
Has your child received other interventions?	NO	YES ☐ speech ☐ PT ☐ counseling ☐ ABA ☐ DIR/Floortime
How long did your child receive the above therapy?		age, duration and location:
Does your child have a medical diagnosis?	NO	YES, please explain From whom? Profession? When?
Does your child have a history of ear infections?	NO	YES, please explain
Did/does your child have ear tubes?	NO	YES (what age? how long?)
Does your child take any medications or have they in the past?	NO	YES, please explain
Does your child have allergies?	NO	YES, please explain
Has your child has any major injuries or hospitalizations?	NO	YES, please explain
Any history of seizures?	NO	YES, please explain

GENERAL INFORMATION		
Any history of motor delays?	NO	YES, please explain ☐ rolling ☐ sitting ☐ crawling ☐ walking
Any history of language delays?	NO	YES, please explain

SLEEPING		
Is sleeping, or was it ever, a concern?	NO	YES, please explain:
What time does your child go to bed?		
What time does your child wake up?		
Does your child wake during the night?	NO	YES, please explain:
What routines do you use to help them return to sleep?		
What mood is your child in generally in the morning?		
Where does your child sleep?		
How long does it take for your child to settle at night?		
What is your bedtime routine with your child?		
Does your child seem to require more or less sleep than other children?	NO	YES, please explain:
Does your child take naps?	NO	YES, please explain:
Any other pertinent information around sleep that we should know?		

FEEDING		
Was your child able to breast feed as an infant?	NO	YES… how long?
If your child was bottle fed were their difficulties or concerns with feeding?	NO	YES, please explain:
Did your child have difficulty with latching or sucking as an infant?	NO	YES, please explain:
Was reflux an issue?	NO	YES, please explain:
Was appetite or weight gain a concern?	NO	YES, please explain:
Do you consider your child a picky eater?	NO	YES, please explain:
Does your child have definite food preferences?	NO	YES
Does your child have a food repertoire of less than 20 foods?	NO	YES
If less than 20 foods what foods will child eat regularly?	please list:	
Does your child have difficulty chewing a variety of foods?	NO	YES, please explain:
Does your child have difficulty swallowing certain foods?	NO	YES, please explain:
Does your child overstuff their mouth during meals or snacks?	NO	YES, please explain:
Does your child appear NOT to notice when they have food on their face?	NO	YES, please explain:
Is your child a messy eater?	NO	YES, please explain:
Does your child eat with utensils?	YES	NO , please explain:

FEEDING		
Does your child get up frequently during meals?	NO	YES, please explain:
Does your child have difficulty or immature patterns around feeding themselves?	NO	YES, please explain:
Please describe a typical mealtime with your child including **where and how they sit, how long they attend to a meal and what routines you use to get them to eat…**		

GROOMING/HYGIENE		
Does your child resist or dislike grooming activities?	NO	YES, please explain: ☐ tooth brushing ☐ hair brushing ☐ face washing ☐ hair cuts ☐ nail trimming ☐ blowing nose
Does your child need excessive help with grooming tasks?	NO	YES, please explain:
Does your child have special routines to assist him/her with completing grooming tasks?	NO	YES, please explain:
Does your child experience any discomfort with bathing or showering?	NO	YES, please explain:
Does your child require excessive help with bathing or showering?	NO	YES, please explain:
Does your child need a specific routine for g/h or bathing?	NO	YES, please explain:

What happens if this routine is disrupted?		Please explain:
DRESSING		
Does your child have trouble putting on any clothing items?	NO	YES, which ones?
Does your child have difficulty managing fasteners?	NO	YES, what type?
Is your child picky about the texture of their clothing?	NO	YES, please explain:
Does your child prefer minimal clothing even when it is cold outside?	NO	YES, please explain:
Does your child wear too much clothing regardless of temperature outside?	NO	YES, please explain:
Do tags or seams bother your child?	NO	YES, please explain:
Do you have special routines to help your child get dressed?	NO	YES, please explain:
Does your child require excessive help to get dressed?	NO	YES, please explain:
TOILETING		
Is your child toilet trained for bowel and bladder?	YES	NO, please explain:
Does your child experience toileting issues like incontinence, bedwetting, constipation, etc?	NO	YES, please explain:
Does your child wear some type of incontinence support at night?	NO	YES, please explain:
Do you have any routines you use to help your child use the toilet at an age appropriate level?	NO	YES, please explain:
Does your child have difficult completing the steps of toileting from clothing management to washing hands?	NO	YES, please explain:

FAMILY/SOCIAL		
Do you limit family or social gatherings because of your child's behavior?	NO	YES, please explain:
Does your child have difficulty at birthday parties?	NO	YES, please explain:
Do you avoid leaving your child with familiar but not routine caregivers for childcare?	NO	YES, please explain:
Do you have difficulty maintaining family relationships with other families?	NO	YES, please explain:
Are you limited in what kind of family activities or hobbies your family pursues due to your child's reactions?	NO	YES, please explain:
Does your child have difficulty tolerating social touch or hugs from others?	NO	YES, please explain:
Do you have routines you need to follow to help your child be successful in social situations?	NO	YES, please explain:
COMMUNITY		
Does your family avoid busy, unpredictable environments due to your child's response?	NO	YES, please explain:
Does your child lack safety awareness in community?	NO	YES, please explain:
If age appropriate, does your child struggle with sleepovers?	NO	YES, please explain:
Does your child have difficulty sitting through public performances?	NO	YES, please explain:
Does your child demonstrate anxiety or stress in age appropriate movies?	NO	YES, please explain:

COMMUNITY		
Do you avoid grocery stores with your child?	NO	YES, please explain:
Does your child have difficulty standing in line?	NO	YES, please explain:
When standing in line does your child have an excessive response when bumped?	NO	YES, please explain:
Does your child seem to not notice being bumped at all?	NO	YES, please explain:
SOCIAL BEHAVIORS		
Does your child demonstrate aggressive behaviors?	NO	YES, please describe them:
Does your child have tantrums that seem excessive?	NO	YES, please describe them (duration/ frequency):
Is your child easily frustrated or overwhelmed?	NO	YES, please describe response:
Does your child appear excessively clingy?	NO	YES, please describe:
Does your child escalate rapidly?	NO	YES, please describe:
Do you notice atypical, repetitive behaviors in your child?	NO	YES, please describe:
Does your child have difficulty communicating his/her needs?	NO	YES
Does your child seem not to hear his/her name being called?	NO	YES

PEER INTERACTIONS/PLAY		
Does your child have difficulty initiating with peers?	NO	YES, please explain:
Does your child struggle to play alone?	NO	YES, please explain:
Does your child prefer sedentary play?	NO	YES, describe:
Does your child prefer excessively active play?	NO	YES, describe:
Does your child have difficulty playing with other children?	NO	YES, please explain:
Does your child destroy toys?	NO	YES, please explain:
Does your child's need for movement impair his/her interactions with peers?	NO	YES, please explain:
What are your child's preferred movements when seeking?	Please describe:	
Does your child seek our specific playground equipment?	NO	YES, describe:
Does your child avoid certain playground equipment?	NO	YES, describe:
Does your child take unnecessary risks when playing?	NO	YES
Does your child seem to get out of control at the playground or in an active environment?	NO	YES, describe:
Does your child avoid messy activities like sand, mud, finger painting, etc?	NO	YES, please explain:
Does your child seem to have weaker muscles than peers?	NO	YES

PEER INTERACTIONS/PLAY		
Is your child delayed in any gross motor skills compared to same age peers (bike, hopping, skipping, jumping, etc)?	NO	YES, which?
Does your child seem to want to control what he/she plays with peers?	NO	YES, please explain:
Does your child struggle to come up with ideas for play?	NO	YES
FINE MOTOR SKILLS		
Does your child have a hand preference?	NO	YES, which
Does your child change hand preference when drawing or coloring?	NO	YES
Does your child change hand grips frequently when coloring or drawing?	NO	YES
If age appropriate is handwriting and issue?	NO	YES
Does your child avoid coloring or drawing?	NO	YES
Does your child have difficulty sitting still during coloring or writing?	NO	YES

SENSORY OVER-RESPONSIVENESS	
My child is bothered by these aspects of clothing…	☐ seams in clothing ☐ tags in clothing ☐ socks ☐ changing from long to short pants ☐ accessories ☐ elastic on clothing ☐ fuzzy or furry textured clothing ☐ wool clothes
My child is bothered by these self care aspects…	☐ washing or wiping face ☐ cutting toenails or fingernails ☐ having hair cut/clipped ☐ hair washing or drying ☐ hair brushing or combing ☐ getting dressed ☐ brushing teeth ☐ getting dirty ☐ having crumbs around mouth ☐ having messy hands ☐ having a messy mouth
My child is bothered by these tactile sensations…	☐ mud ☐ finger paint ☐ glue ☐ play dough ☐ foods ☐ haircare products ☐ kissing ☐ coarse carpet ☐ light touch
My child is bothered by these visual sensations…	☐ brightly colored patterns ☐ fluorescent lights ☐ fast moving images in the movies or on TV ☐ visually cluttered environments ☐ busy pictures in books or complex artwork
My child is bothered by these smells…	☐ perfume/cologne ☐ cleaners/disinfectants ☐ bath products ☐ soaps ☐ air fresheners
My child is bothered by these aspects of food and eating…	☐ salty foods ☐ soft foods ☐ lumpy foods ☐ slimy foods ☐ chunky soup ☐ spicy foods ☐ bread crust ☐ food prep/cleanup ☐ new/unfamiliar foods

SENSORY OVER-RESPONSIVENESS	
My child is bothered by these sounds…	☐ sound of utensils against each other ☐ clothing that makes noise ☐ door bell ringing ☐ dog barking ☐ sirens ☐ alarms ☐ radio or TV in background ☐ fluorescent lights ☐ clock ticking ☐ construction or landscape equipment ☐ water running or dripping in the background ☐ toilet flushing ☐ appliances or small motors ☐ concerts ☐ large gatherings ☐ restaurants ☐ parades ☐ malls ☐ gymnasiums
My child is bothered by these aspects of movement…	☐ climbing activities ☐ walking or climbing up stairs ☐ experiencing of heights ☐ walking or standing on moving surfaces ☐ playing in the playground jungle gym ☐ playing on playground swings and slides ☐ going on amusement park rides ☐ going up/down escalators ☐ chewing foods
SENSORY UNDER-RESPONSIVENESS	
My child has a less intense response than others to…	☐ shots at the doctor's ☐ bruises or cuts ☐ getting hurt ☐ being touched on the arm ☐ wet or dirty diapers ☐ dirt on himself/herself ☐ objects that are too hot/cold ☐ bumping into things or falling over objects
My child does not seem to notice…	☐ food or liquid on mouth ☐ hands or face that are messy ☐ drooling or food that has fallen out of mouth ☐ the need to use the toilet ☐ feelings of hunger ☐ over-filling mouth when eating ☐ feelings of being full ☐ strong or noxious odors

SENSORY UNDER-RESPONSIVENESS	
My child not seem to notice…	☐ activity in a busy environment ☐ an object coming toward them quickly (ball) ☐ someone interring or leaving a room ☐ materials or people in the room needed to complete an activity
My child does not typically respond…	☐ when his/her name called or touched to get their attention ☐ when a new sound is introduced ☐ to unexpected loud sounds ☐ when given directions the first time ☐ to a normal volume speaking voice
My child…	☐ performs movements in a slow plodding fashion ☐ gives little indication of like or dislike from movement ☐ appears to be in his/her own world ☐ does not visually scan the environment ☐ leaves clothes twisted on body
SENSORY CRAVING	
My child is constantly seeking…	☐ swinging ☐ being upside down ☐ jumping and crashing ☐ bumping, pushing, hitting or hugging other children ☐ fidgeting, wiggling which interfere with daily routines ☐ twirling/spinning throughout the day ☐ movement in chair during class, meals or other situations ☐ deliberate falling when running or playing ☐ movement without regard for safety ☐ bumping or pushing against objects or walls ☐ flapping/clapping hands, biting self, or other repetitive actions ☐ changing from one activity to another without completion ☐ pushing pulling and hanging off things
My child is constantly seeking…	☐ to look at spinning objects ☐ fast changing TV or movie segments ☐ flickering or blinking lights ☐ visually stimulating scenarios like lava lamps, etc ☐ to stare at people or objects

SENSORY CRAVING	
My child is constantly seeking…	☐ to touch others to the point of irritating them ☐ to much affectionate touch with others ☐ vibrations from speakers, washers/dryers ☐ to touch or feel objects ☐ to be held ☐ head banging, hand biting, pinching, scratching and hair pulling ☐ to splash excessively during bath time
My child is constantly seeking…	☐ to lick, suck, chew on non-food items ☐ to eat crunchy, chewy, or hard foods to the exclusion of other textures ☐ to put things in mouth ☐ excessive kissing
My child is constantly seeking…	☐ foods with strong flavors ☐ to smell people or pets ☐ to deliberately smell or taste objects or toys while playing
My child is constantly seeking…	☐ talking and has difficulty taking turns with conversation ☐ to speak in a loud voice ☐ to make a lot of noises during play activity ☐ to increase the volume of the TV or music ☐ to make strange sounds
POSTURE	
My child does not…	☐ have a preferred hand ☐ does not hold paper with other hand while cutting or writing ☐ reach across his or her body to grab a toy
My child does not appear to have enough strength…	☐ to turn knobs/handles that require some pressure ☐ so has a loose grasp on objects like pencils or carrying things ☐ so holds things tightly but cannot sustain ☐ to lift heavy objects ☐ so appears weaker than other children same age children ☐ to hold a pencil the same way as most other people
My child has difficulties with these activities…	☐ balancing when a bus or car stops quickly ☐ balancing during motor activities like biking, karate, etc ☐ keeping good desk posture (slumping, etc) ☐ turning head to look instead of turning whole body ☐ standing or holding a particular position ☐ catching self when falling

POSTURE	
My child…	☐ feels stiff and awkward when held ☐ keeps mouth open most of the time ☐ tires easily ☐ sits partly on/off the chair ☐ feels loose or floppy when I lift them up or move them around to get dressed ☐ uses one hand or the other but avoids using to hands together in play ☐ needs encouragement for heavy work
My child has difficulty coordinating the 2 sides of his/her body to…	☐ play rhythmic clapping games ☐ pump self on swing ☐ jump with both feet together ☐ ride a bicycle, tricycle, or other wheeled toy
My child has difficulty with the following visual activities…	☐ keeping track of place on page ☐ following a moving object with eyes ☐ copying from a blackboard to paper
PRAXIS	
My child has difficulty with these language activities…	☐ being understood when he/she speaks ☐ unable to follow 2-3 step verbal directions
My child demonstrates difficulties in these motor activities…	☐ tasks with multiple steps ☐ learning exercise steps or routines ☐ learning new motor tasks ☐ following the steps of a recipe ☐ maintaining or copying rhythms ☐ balancing ☐ hopping, jumping, skipping, or running ☐ climbing, jumping, or walking on bumps or uneven ground ☐ sports or games ☐ climbing on or over objects ☐ riding a bike or tricycle ☐ climbing or playing on playground equipment ☐ catching a ball
My child…	☐ appears clumsy and seems not to know how to move their body ☐ prefers sedentary play ☐ approaches new motor activities in an overly cautious way ☐ gets lost easy ☐ is accident prone ☐ talks self through tasks ☐ uses inefficient ways of doing things ☐ tends to break toys/objects when has problem using them ☐ has difficulty formulating a plan or idea for action

PRAXIS	
My child has difficulty with these fine motor activities…	☐ playing with small manipulative toys (beads, legos) ☐ blowing bubbles or whistles ☐ snapping fingers ☐ grasping a pencil or crayon ☐ applying paste to toothbrush
My child has difficulty with these school activities…	☐ drawing, coloring or copying ☐ cutting and pasting ☐ staying between the lines when coloring or when writing ☐ poor handwriting
My child has difficulty with these daily tasks…	☐ licking an ice cream cone ☐ using a spoon or cup ☐ handling eating utensils ☐ getting dressed or undressed ☐ placing arm or leg correctly in clothing ☐ tying shoes ☐ fasteners
My child…	☐ is a sloppy, messy eater ☐ eats or dresses slowly ☐ puts clothes on backwards or inside out ☐ looks disheveled
SENSORY DISCRIMINATION	
My child has trouble finding…	☐ utensils on the table or in the sink ☐ desired item in a drawer or on a shelf ☐ desired garment in a closet ☐ socks that match ☐ objects in distracting backgrounds (shoes in messy room, toys in junk drawer) ☐ the difference between printed figures that seem similar (b and d or + and x) ☐ a familiar face in a crowd ☐ information on a blackboard ☐ things that are moving from those that are not
My child has trouble judging…	☐ the amount of force needed for a task ☐ the amount of pressure with markers, crayons and glue sticks (breaks or flattens) ☐ timing and distance ☐ if he/she is moving or things around them are moving ☐ where food is within his/her mouth
My child has trouble distinguishing (without looking)…	☐ objects in pockets ☐ what is in his/her hand ☐ what is touching him ☐ buttons and button holes

SENSORY DISCRIMINATION	
My child…	☐ tends to examine toys by touching and feeling rather than looking ☐ examines things by putting them in his/her mouth (over the age of 1.5 years)
My child has trouble distinguishing…	☐ location of sounds ☐ what is said ☐ the words to a song ☐ specific sounds that are similar ☐ the taste of different foods ☐ applying paste to toothbrush
Are there any other concerns you may have regarding your child or dynamics in your family in relation to your child that may not have been addressed in this questionnaire?	
After reflecting on this questionnaire what goals do you have for your child? If you could wave a magic wand what would you wish for your child and your family? Please be specific. Relate to specific challenges or behaviors if possible.	
Whom may we thank for referring you to Blossom Therapeutics?	

If you have any further questions please contact Blossom Therapeutics @ 541-617-8769 or info@blossomtherapeutics.com. You may also contact your evaluating OT as well.
Thank you.
The Blossom Therapeutics Team

Blossom Therapeutics History and Physical developed using the SPD sensory checklist created by the STAR Center, Denver, CO

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby authorize (Name of Client or Parent/Guardian)

Blossom Therapeutics to release and share any and all information pertinent to:

Name/DOB:_____

to the following providers and/or facilities:

_____

(name, address, #)

_____

(name, address, #)

I do understand that this release and sharing of information will include, but not be limited to conversations, therapy sessions, records, reports, determinations, evaluations and factual information regarding myself and/or family member(s) who are minors. I understand that this action is taken to assist Blossom Therapeutics in working with me and/or my family.

This authorization is voluntary and remains in effect until _____, unless specifically revoked by written notice to the agency or person. A photocopy of this release is as effective as the original.

_____

SIGNATURE OF INDIVIDUAL/DATE

_____

SIGNATURE OF PARENT/GUARDIAN/DATE

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW ALL POINTS BELOW CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operations of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval/ payment for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval/ payment for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business

activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your treating provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Disease Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician, provider, or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS – Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician/ provider is NOT required to agree to a restriction that you may request. If the physician/ provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper

copy of this notice from us upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician/ provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you via mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your provider of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before September 1, 2009.

Acknowledgment of Receipt of Privacy Practices

I, _____have received a copy of Blossom Therapeutics Notice of Privacy Practices with an effective date of September 1, 2009.

Name of Client: _____

Address of Client: _____

_____

Signature of Client: _____ **Date:**_____

Name of Witness:

Signature of Witness: _____ **Date:**_____

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RELEASE AND ACKNOWLEDGMENT OF RISK

I understand and acknowledge that Blossom Therapeutics, LLC, an Oregon limited liability company ("**Blossom**") provides use of its leased facilities to independent contractors, including _____ ("**Provider**") for Provider's therapy or other health care services (the "**Activity**"). The Activity presents known and unknown risks that could result in injury, death, illness, or other damage to my child or other legal ward ("**Participant**"), myself, or to my property.

I acknowledge that (*enter Participant's name*) _____ is physically capable of participating in the Activity.

I understand that my sole recourse is against Provider for any and all liabilities, claims, demands, or actions for injury or death to Participant, myself, to others, or injury to my property, or which are in any way connected with Participant's participation in the Activity.

I hereby voluntarily release, forever discharge, and agree to hold harmless and indemnify Blossom and Provider, and all other persons or entities involved with the Activity, including the members, managers, agents or employees of Blossom and Provider, from any and all liabilities, claims, demands, or actions for injury or death to Participant, to myself, to others, or injury to my property, or which are in any way connected with Participant's participation in the Activity, other than for gross negligence or willful misconduct by such persons or entities.

THIS IS A RELEASE

My signature below indicates that I have read this release and acknowledgement of risk and understand it completely. I UNDERSTAND THAT BY SIGNING THIS DOCUMENT I LIMIT MY RIGHT TO MAKE A CLAIM OR FILE A LAWSUIT FOR INJURY TO ME, MY CHILD (OR OTHER LEGAL WARD) TO OTHERS, OR TO MY PROPERTY. NEVERTHELESS, I ENTER INTO THIS AGREEMENT FULLY AND VOLUNTARILY AND AGREE THAT IT WILL BE BINDING UPON ME, MY HEIRS, ASSIGNS AND LEGAL REPRESENTATIVES. I FURTHER AGREE THAT IF ANY PART OF THIS AGREEMENT IS UNENFORCEABLE, THE REMAINDER SHALL CONTINUE TO BE EFFECTIVE TO THE MAXIMUM EXTENT PERMITTED BY LAW.

Signature of Participant's Parent (or Guardian): _____

Name of Participant's Parent (or Guardian): _____

Date: _____, 20__

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

If you choose to sign this Authorization, you are granting Provider permission to share certain protected health information about Participant. Provider may not condition treatment, payment, enrollment or eligibility for benefits on your signature of this Authorization.

I authorize Provider to disclose (in accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder ("**HIPAA**")), to the parties listed below, protected health information that relates directly or indirectly to Participant's therapy or other health care. The foregoing protected health information may be disclosed to (*specify*): Blossom Therapeutics, LLC and

_____

_____

_____.

This authorization is intended to provide Provider with the authorization necessary to allow them to disclose protected health information regarding Participant to the persons described in the paragraph above for the purpose of allowing each of them to provide therapy or other health care to Participant.

Information disclosed by Provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the HIPAA privacy rules of 45 CFR Part 164.

This authorization may be revoked by a writing signed by me.

This authorization will expire three years after the date below, unless validly revoked prior to that date.

Signature of Participant's Parent (or Guardian): _____

Name of Participant's Parent (or Guardian): _____

Date: _____, 20__

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Insurance Form

Blossom Therapeutic, LLC provides therapies that are covered by most insurances. We do everything possible to insure you receive the maximum benefits from your provider. Insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance or any other balance not paid by your insurance.
On the following page is a guide to help you better understand your insurance and navigating your policy.

Insurance Information: Please provide a copy of your insurance card, front and back.

Primary Insurance Company:_____ Phone:_____

ID Number:_____ Group Number:_____

Secondary Insurance Company:_____ Phone:_____

ID Number:_____ Group Number:_____

Financially Responsible Guarantor:_____

Relation to patient:_____ Address:_____

Phone:_____ Email:_____

Please initial each line below and sign the bottom indicating your understanding of our best practice regarding your insurance.

____I authorize the release of all medical information necessary to process and insurance claim.

____I assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and other health plans to **Blossom Therapeutics, LLC**

____I authorize my insurance carrier to make payments directly to **Blossom Therapeutics, LLC**

____I understand the financial policy established by **Blossom Therapeutics, LLC.**

____I understand that balances left unpaid over 90 days from the date of service may be assessed late fees.

_____ _____
Child/Client Printed Name Parent/Guardian Printed Name

_____ _____
Date Parent/Guardian Signature

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Helpful Hints for Navigating Your Insurance Policy

1. Call the customer service number on the back of your insurance card.
2. Ask the following bolded questions to obtain your benefits for Occupational Therapy (sometimes these services are called Outpatient Rehabilitation)

What is the individual deductible for my child? If the deductible has not been completely met, the remaining amount will be billed to you, the client, before the co-pay or co-insurance applies.
Total: _____ Met: _____

Does the deductible apply for Occupational therapy services?
❑ Yes ❑ No

What is the out of pocket maximum (OOP)?
Total: _____ Met: _____

Once the deductible is met, do I have a co-pay, or co-insurance?
This is the amount that is billed to you for each visit.
Co-pay amount: _____ OR Co-insurance percentage: _____

Is there a visit limit?
❑ Yes, _____ visits per year and _____ visits are remaining ❑ No

Does my plan require prior authorization? ❑ Yes ❑ No
If the answer is yes, Blossom Therapeutics will submit the authorization on your behalf. Please be aware that authorizations may impact the scheduling process.

Don't hesitate to ask your insurance provider any questions for better clarification regarding your coverage. They are the best equipped to answer questions specific to your plan.

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Blossom Cancellation/No-Show Policy

We are grateful you have chosen the Blossom Therapeutics' team as your child's occupational therapy provider. Our number one priority is the support and growth of your child toward their goals. This can only be accomplished with consistent frequency and duration of therapeutic intervention. Our cancellation and no-show policy is a means to insuring your child is able to meet their goals and for us to meet your expectations as your child's care providers.

We require 24-hours notice in the event of a cancellation. Please contact your primary therapist directly to insure they receive your message in a timely manner. Please be prepared to be given an alternative time to come in, which may be with a different therapist. All of our therapists are experienced professionals and they will consult with your child's primary therapist to insure excellent continuum of care.

We understand that children get sick at the last minute. And, of course, we want to protect your child's health as well as every child and family member in our clinic. So please contact us if your child has a fever, diarrhea, significant coughing or a runny nose. Our number one priority is keeping our community healthy and thriving. **However, in the event that a short notice cancellation occurs, a $60 fee will be billed to you.** We are not interested in charging you this fee, which is not reimbursable by your insurance carrier. Our primary goal is to nurture your child's development and this can only be done with consistency. The reason for this fee is multi-faceted. When we don't have enough advance notice, multiple people are impacted: your child, because they do not receive the prescribed treatment by their physician; the therapist who could have filled that space with another family anticipating therapy; and a family who has been waiting to be offered an appointment by our practice from our waitlist.

We do our best to provide you and your child with a predictable schedule of the same time and day each week. We believe that this promotes consistency for everyone involved. After 2 cancellations/no shows in a month, it is at our discretion that you will be removed from your regular weekly spot and be placed on our Flex Schedule, until consistency is re-established. Our Flex Schedule offers flexibility for families to call into the clinic to make a "week-of" appointment, either to fill cancellations or other openings, as they arise.

Thank you so much for your understanding and support.

--The Blossom Therapeutics Team

Signed:_____(Caregiver) Date:_____

Witnessed:_____(Therapist) Date:_____

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Consent to Release Pictures or Video

Welcome to the Blossom Therapeutics Family. It is our mission to provide your child and your family with the most wholistic, comprehensive, evidence based therapeutic intervention available. This means we are continually evolving our therapeutic approach. Video is a powerful tool for us to learn, support your child and educate you as a parent if the need arises. Video also allows Blossom therapists to self-reflect and thus refine our intervention to meet the very individual needs of your child. Video will only ever be used within the boundaries of Blossom's clinic and our therapists' educational endeavors.

We also like to share successes through photos that may be used on social media. As always, your verbal consent will be requested before this is ever done.

By signing below, you are authorizing that Blossom may occasionally photograph and/or video your child and our therapists for the above stated reasons but only after verbal confirmation with you prior to using video or photo.

- ☐ Consent for video/photo for educational purposes
- ☐ Consent for video/photo for social media

You will be provided a signed copy of this consent form for your records. Thank you for your generous support.

Sincerely,
The Blossom family

_____
Child's Name

_____ _____ _____
Parent Signature Print Name Date

_____ _____ _____
Therapist Signature/Title Print Name Date