

Teri Kozlowski, OTR LLC dba
TeeKoz Kids
Pediatric Occupational Therapy



Pediatric Occupational Therapist
SIPT Certified
NDT Trained in Infants and Pediatrics
(301) 933-5688 Ext. 3

MD License# 01882
Private Practice
Consultation
Fax (301) 933-5686

Dear Client: _____

This packet contains forms to be completed and returned by mail or fax prior to your appointment. Please return all forms by mail or fax one week prior to the evaluation or treatment date. If you fax the forms, please bring the originals on the date of the appointment. If you have additional information, such as school or therapy reports, please forward those as well. Should you have questions about the completion of these forms, please call (301) 933-5688, ext. 3. Please return forms to:

Teri Kozlowski, OTR LLC
TeeKoz Kids Pediatric Occupational Therapy
10605 Concord Street, Suite 102
Kensington, MD 20895

Sincerely,

TeeKoz Kids

Teri Kozlowski, President
Teri Kozlowski, OTR LLC

Please make sure to complete the following items to help prepare for the evaluation or initiation of treatment.

- Complete the packet.
- Send or fax the completed packet. If the packet is faxed, please bring original forms to evaluation/treatment date.
- Send other relevant reports.

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Current Fee Schedule and Payment Policy as of September 1, 2016

The following is the current Fee Schedule and Payment Policy for services to be provided to your child by Teri Kozlowski, OTR LLC (TeeKoz Kids) and/or its consultants (the "Company"). Please understand that the Company reserves the right to change and/or modify the fees set forth below, but you will receive thirty (30) days advanced notice of any increase in such fees. All fees and costs shall be due and payable in accordance with the Agreement to Terms of Payment.

Fee Schedule:

Individual Therapy:

Office Visit - \$150.00 per hour

Food School Visit - \$180.00 per hour

Includes prep and clean up time.

Occupational Therapy Full Evaluation - \$700

Includes administration, scoring, written analysis and one-hour consultation to discuss results.

Sensory Integration and Praxis Test - \$875

Includes administration of SIPT, scoring, written analysis and meeting with parents to discuss results.

Consultations - \$200 per hour

This fee includes clinic visits, parent/related service provider phone calls and follow-up meetings (as needed).

School Visit - Home Visit - \$200.00 per hour

This fee includes school or home observations, telephone consults with related service providers, parent consultation and written reports.

Dyad - \$125 per hour with 1 therapist - \$150 per hour with 2 therapists.

Social Skills or Food School Group sessions - Cost will be dependent on number of children in the group and number of therapists needed to run the group.

All hourly rates are billed in quarter hour increments.

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Payment for Services

For your convenience, we accept Visa, MasterCard, Discover and American Express credit cards as well as HSA and Debit Cards. *We do not accept checks.* Credit Card and Debit charges will be processed on or about the eighth day of the month following your treatment(s) and itemized statements will be mailed to you. Sara McCain is the point of contact for all billing and collections questions.

Please sign and return the Credit Transaction Form along with the remainder of the forms to:

Teri Kozlowski, OTR, LLC
TeeKoz Kids
10605 Concord Street, Suite 102
Kensington, MD 2895

All other correspondence regarding billing should be mailed to this address:

TeeKoz Kids
Attn: Sara McCain
164 W. Main Street, Suite F
New Market, MD 21774

Billing@TeeKozKids.com or *(301) 865-9740, Ext 100

*Phone will be answered by Lighthouse Wealth Management, just ask for Sara.

Cancellation and No-Show Policy

Cancellations less than 24 hours in advance of the scheduled appointment will be billed at the full rate if the session cannot be filled. For all cancellations, please call your treating therapist at (301) 933-5688 and leave a message in your therapists' mailbox. Appointments that are not cancelled are considered "no-shows". These appointments will be billed at the full rate.

WHEN SUBMITTING YOUR INVOICE FOR REIMBURSEMENT FROM YOUR INSURANCE COMPANY, BE SURE YOU ARE NOT REQUESTING THE CHECK BE SENT TO US OR YOUR THERAPIST

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Credit/Debit/HAS Card Transaction Processing Authorization Form

- Yes, I would like you to automatically charge my credit card for services rendered each month.
- Yes, I would like to have my checking account debited for services rendered each month.

Card Type: Visa MasterCard AmEx Discover

Card # _____ Exp Date: _____

Name on Card and Billing Address:

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree as follows: (i) the undersigned does hereby authorize and agree that Teri Kozlowski, LLC (TeeKoz Kids) and/or its duly authorized agent (the "Company") has the right from time to time to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed to the Company and/or its consultants, (ii) the undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt or other form and if any merchant services, credit card company, or bank requests to view the undersigned signature on a sales charge receipt or other form, the Company may provide such company with a copy of this Agreement and such shall be deemed conclusive proof that the undersigned approved and authorized the charge and/or debit at issue, and the undersigned does hereby waive any right to dispute its authorization to such charge based on an invalid or non-existent signature. The undersigned understands and agrees that the above payment option and charges or debits will continue each month for services rendered by the Company and/or its consultants until such time as the undersigned has provided written notice to the Company to stop such automatic charges and/or debits. The undersigned shall be fully responsible for ensuring that it has sufficient credit and/or funds to cover the charges or debits and shall indemnify the Company against all costs incurred as a result of any declined charge or debit.

AGREED AND ACCEPTED:

Signature

Date

Print Name

Main Phone

Print Name of Patient

**All credit cards will be processed on or about the 8th day of each month.*

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Agreement to Terms of Payment

I, _____ (*print name*), acknowledge and accept full and complete responsibility for payment of all services rendered to my child or any child under my care by Teri Kozlowski, OTR LLC (TeeKoz Kids) and/or its consultants. I acknowledge that I have received written explanation of the fee schedule, cancellation policy, and payment policy and I agree to both.

I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered to my child or any child under my care are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between myself and Teri Kozlowski, OTR LLC (TeeKoz Kids), and are not related to potential insurance coverage. I understand that Teri Kozlowski, OTR LLC (TeeKoz Kids) may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by Teri Kozlowski, OTR LLC (TeeKoz Kids) and/or its duly authorized agents of any information that is requested by my insurance company.

Signature of Parent or Legal Guardian

Name of Patient

Printed Name

Date

**WHEN SUBMITTING YOUR INVOICE FOR REIMBURSEMENT, BE SURE YOU ARE NOT
REQUESTING THE CHECK BE SENT US OR YOUR THERAPIST.**

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Acknowledgement and Assumption of Risk

I, _____ (*print name*) acknowledge and agree to have my child (or the child under my care), _____ (*print child's name*) receive occupational therapy services from Teri Kozlowski, LLC., Teri Kozlowski OTR LLC (TeeKoz Kids) and/or any independent contractor under the foregoing at TeeKoz Kids. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Teri Kozlowski, OTR LLC, Teri Kozlowski, any of their independent contractors, and TeeKoz Kids harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belonging.

Signature

Date

Print Name

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Referral Form

Child's Name: _____ Age: _____ Date of Birth: _____

Address: _____

Patient lives with:

- Mother
- Father
- Both
- Other: _____

Referred by: _____ Pediatrician: _____

Mother/Caregiver 1 Name: _____

Preferred Phone: _____ Is this a cell phone home phone

Preferred Email Address: _____

Father/Caregiver 2 Name: _____

Preferred Phone: _____ Is this a cell phone home phone

Preferred Email Address: _____

School/Daycare: _____

Teacher Name: _____

Phone and/or email: _____

Parental Concerns: Please describe your concerns regarding your child and reasons for referral:

Medical Information: Please check all that apply and explain:

Childhood Illnesses (measles, mumps, chicken pox): _____

Surgeries: _____

Genetic Testing/Results: _____

Seizures: _____

Allergies (food, latex, meds -- please list): _____

Restrictive Diet: _____

Hearing Problems: _____

Chronic Ear Infections: _____

Ear Tubes: _____

Vision Problems: _____

Attention: _____

Other Medical Conditions: _____

Developmental Information: Has your child met their developmental milestones on time? Please check all that apply and explain:

- Gross Motor Skills: _____
- Fine Motor Skills: _____
- Speech Skills: _____
- Social Skills: _____
- Dressing: _____
- Toileting: _____
- Feeding/Eating: _____
- Sleeping: _____

Regulation Information: Does your child have challenges with any of the following? Please check all that apply and explain.

- Behavior: _____
- Attention: _____
- Frustration tolerance: _____
- Transitions or changes to routines: _____

Social/Play Information: Does your child have challenges with any of the following? Please check all that apply and explain.

- Meal Time: _____
- Limit Setting: _____
- Group play/participation: _____
- Independent play: _____

What are your child's favorite things to play and preferred activities? _____

Current or Past Providers

Occupational Therapist: _____

Telephone: _____

Address: _____

Physician: _____

Telephone: _____

Address: _____

Speech Pathologist: _____

Telephone: _____

Address: _____

Psychologist **Psychiatrist** _____

Telephone: _____

Address: _____

Educational Consultant: _____

Telephone: _____

Address: _____

Optometrist **Ophthalmologist** _____

Telephone: _____

Address: _____

Neurologist: _____

Telephone: _____

Address: _____

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Consent to Release Form

I, _____ (*print name*) give my permission and consent to Teri Kozlowski, LLC, Teri Kozlowski OTR, (TeeKoz Kids) and their respective consultants and agents (hereinafter, collectively, the "Company") to discuss and speak with school officials, teachers, psychiatrists, medical doctors, other occupational therapists, insurance representatives, and other professionals (collectively, "Third Party Professionals") regarding my child (or the child under my care) as such may be needed in connection with the treatment and/or evaluation of such child by the Company.

In addition, the Company is authorized to receive any records, files, charts, and other documentation and information from such Third-Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third-Party Professional to the Company. Any person who is provided a copy of this document may rely on it as the undersigned's full and unconditional consent to the release of any and all information pertaining to the child. The undersigned further authorizes the Company to release any and all information pertaining to the treatment and/or evaluation of the child to any Third-Party Professional that may in any way be involved in the treatment and/or evaluation of the child.

The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, as set forth above, the undersigned understands and agrees that they are agreeing to the release of such information notwithstanding the protections under HIPPA, provided, however, it is understood and agreed that the Company will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of treating or evaluating the child.

The undersigned, for his/herself and his or her successors and assigns, does hereby hold the Company harmless from any and all claims relating to the release of information as provided above, and do hereby waive and release any claim against the Company relating to the release of such information as provided above.

AGREED AND ACCEPTED:

Signature

Date

Print Name

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Consent Form

Name	Telephone Number	Initial/Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature Initial Date

I, _____ (*print name*) give my permission to Teri Kozlowski OTR, LLC and TeeKoz Kids to speak with the above listed professionals regarding my son/daughter: _____.

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Parental/Consent Form

I, _____ (*print name*), give my permission to Teri Kozlowski, Teri Kozlowski OTR LLC, TeeKoz Kids and their consultants (hereinafter, collectively, the "Company") to observe my child (or the child under my care) _____ (child's name), at _____ School. I understand that during this observation, the Company may speak with the classroom teacher and other professionals at the school about my child.

Signature

Date

Print Name

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Your Privacy Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: 09/01/2018

TeeKoz Kids is required by law to keep your child's health information safe. This information may include:

- notes from your child's doctor, teacher, or other health care provider
- your child's medical history
- your child's test results
- treatment notes
- insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPAA for short. We will ask you to sign a paper saying that you have been given this notice.

Read this notice at any time to see how your child's health information can be used and who can see it.

How Your Health Information May be Used or Shared

We may use or share your child's health information without your permission for the following reasons:

- **Treatment.** We may share information with doctors and other health care providers who care for your child. For example, if your child's doctor orders occupational therapy, we will share the results of our treatment with that doctor.
- **Payment.** We may use and share information about the treatment your child receives with your insurance company or other payer to help you receive payment for services. This may include sharing important medical information. We may share information to:
 - get the insurance company's permission to start treatment
 - get permission for more treatment

- **Health Care Operations.** We may use and share your child's health information to run the clinic and make sure all patients receive good care. For example, we may use your child's health information to:
 - See how well our services are working
 - See how well our staff is doing
 - See how we compare to other clinics
 - Make our services better
 - Help others study health care services

Your child's health information may also be used or shared without your permission for:

- **Abuse and Neglect.** We may share your child's health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **As Required by Law.** We will share your child's information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Government Functions.** Your child's information may be shared for national security or military purposes.
- **Information about a Person Who Has Died.** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Marketing.** We may use your child's information to let you know of other services that might be of interest to you.
- **Public Health Risks.** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight.** We may use or share your child's information to report to agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
- **Research.** We may share your child's health information with researchers to be included in their research project. Information will only be shared for projects that have been through a special approval process. These projects have rules to protect your child's privacy, too.
- **Threats to Health and Safety.** Your child's health information may be shared if it is believed that it will prevent a threat to your child's health and safety or the health and safety of others.

When Your Permission is needed to use or share your health information:

You must give us permission to use or share your child's health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your child's information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights

You have the right to:

- **Ask us not to share your child's information.** You can ask us not to use or share your child's information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your child's care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask us in writing. We will do all we can to do as you ask.
- **Look at and copy your child's health information.** You have the right to see your child's health information and get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your child's health information.** You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your child's information was used or shared.** You can ask us to tell you when your child's information was shared and with whom we shared it. There are some rules about this:
 - You need to ask us in writing.
 - You must tell us the dates you are asking about and if you want a paper or electronic copy.
 - You may get information going back 6 years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.
- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.
- **File complaints.** You can file a complaint with us or with the government if you think that
 - Your child's information was used or shared in a way that is not allowed
 - You were not allowed to look at or copy your information
 - Any of your child's rights were denied

Who is Covered by This Notice

The people that must follow the rules in this notice are:

- All occupational therapists working at TeeKoz Kids Pediatric Occupational Therapy.
- Anyone who is allowed to add health information to your child's file, including students and other staff

Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we did something wrong with your child's information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints, go to www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have any questions about this notice or your privacy rights, please ask your occupational therapist or contact TeeKoz Kids Pediatric Occupational Therapy.

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Acknowledgement That You Have Received Our Privacy Notice

TeeKoz Kids Pediatric Occupational Therapy is required by law to keep your child's health information safe. This information may include:

- Notes from your child's doctor, teacher, or other health care provider
- Your child's medical history
- Your child's test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your child's health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

Your Child's Name

Date

Print your name

Relationship to patient

Signature

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Therapist Contact Information

Jenny Post Gorski	(301) 933-5688	Ext 2	jenny@teekozkids.com
Sami Cook	(301) 933-5688	Ext 1	sami@teekozkids.com
Teri Kozlowski	(301) 933-5688	Ext 3	teri@teekozkids.com
Nancy Rudisill	(301) 933-5688	Ext 4	nancy@teekozkids.com

Billing

Billing (301) 865-9740 billing@teekozkids.com

Services Rendered at:
10605 Concord Street
Suites 101, 102 and 106
Kensington, MD 20895

Directions:

From 495, take Connecticut Avenue (185) North. Right at light at Plyers Mill Road. Immediate left onto Concord Street. Concord Office Building on the right across the street from Sunoco. Parking is to the right.

