Children's TherAplay
The Children's TherAplay Foundation, Inc.

2022 Patient Information Update

If any of the below information has **changed** in the last three months, please provide updated information. You may skip this page if no information has changed.

Client Name: ______________________________
DOB: ____________________ Gender: ____________________
Diagnosis: ______________________________
Address: ______________________________
City, State, Zip: ____________________ County: ____________________

Guardian 1 Name: ______________________________
Home Phone: ____________________ Cell Phone: ____________________
Email: ______________________________

Guardian 2 Name: ______________________________
Home Phone: ____________________ Cell Phone: ____________________
Email: ______________________________

Referring Physician Name: ______________________________
Address: ______________________________
City, State, Zip: ____________________ Phone:__________ Fax: __________
Email: ______________________________

Insurance Providers:

Medicaid Case Manager: ______________________________
Phone:__________Fax:____________________E-mail____________________
Client's RID #:____________________Effective Date: ____________________
Please choose one of the following: ❑ Traditional ❑ Waiver ❑ Risk Based Managed Care

Children's Special Health Care Services
Children's Special Health Care ID#:____________________Effective Date: ____________________

Private Insurance Company: ______________________________
Address: ____________________ City, State, Zip: ____________________
Insured's Name: ____________________ DOB: ____________________
Relationship to client: ____________________ SSN: ____________________
Policy/Group #: ____________________ ID #: ____________________
Phone: ____________________

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Authorization for the Disclosure of Protected Health Information

1. 1. Child's Name: ______________________________________ Parent/Guardian's: Name: ______________________________________

2. By signing below, I hereby authorize my child's Protected Health Information to be disclosed. The Protected Health Information I am authorizing for disclosure is the following:

   ❑ "Standard" release of all information maintained by Children's TherAplay Foundation, Inc. (Includes evaluation, daily therapy notes and progress notes, etc.)
   ❑ Specific information from my child's chart: ____

3. The person or group of people who are authorized to disclose my child's Protected Health Information are as follows: The Children's TherAplay Foundation, Inc.

4. I hereby request The Children's TherAplay Foundation, Inc. to disclose my child's Protected Health Information to the following person(s) or institutions(s):
   - Name of person or parties to receive your child's medical information: ____
   ____

   - Please indicate where we should mail your child's medical information (or any alternative instructions for delivery, such as email or fax): ____

5. This authorization will expire 60 days from signing, unless an alternative date is indicated: _____________________________________

6. I understand that I have the right to revoke this Authorization, if the revocation is in writing, at any time by sending a written request to The Children's TherAplay Foundation, 9919 Towne Road, Carmel, IN 46032. I am aware that my revocation will not be effective regarding the uses and disclosures of content by Children's TherAplay made in reliance on this HIPAA Authorization and that have been made prior to receipt of my revocation.

7. I understand that The Children's TherAplay Foundation, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

8. I understand that my child's Protected Health Information that is disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my child's Protected Health Information will no longer be protected by the law.

9.. I understand that if I am requested to sign this Authorization by The Children's TherAplay Foundation, Inc., that (i) I will be given a copy of this Authorization; (ii) I may inspect or copy the information to be used or disclosed; and (iii) I may refuse to sign this Authorization.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the disclosure of my child's Protected Health Information in accordance with the terms of this Authorization.

____ ____
Signature of Parent or Guardian Signature of Parent or Guardian

______________ ______________
Date Date

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Authorization for the Disclosure of Protected Health Information on Social Media

1. Child's Name: ______________________________________ Parent/Guardian's: Name: _____________________________________

2. By signing below, I hereby authorize my child's Protected Health Information to be disclosed. The Protected Health Information I am authorizing for disclosure is the following:

   ❑ "Standard" release of all information maintained by Children's TherAplay Foundation, Inc. (Includes evaluation, daily therapy notes and progress notes, etc.)
   ❑ Specific information from my child's chart: My child's name; child's photo or videos while receiving therapy or other services at Children's TherAplay; and, information related to my child's progress, goals, and treatment (excluding copies of evaluations, notes, and records), including content that was created or existed before, on or after the date of the HIPAA Authorization.

3. The person or group of people who are authorized to disclose my child's Protected Health Information are as follows: The Children's TherAplay Foundation, Inc.

4. I hereby request The Children's TherAplay Foundation, Inc. to disclose my child's Protected Health Information to the following person(s) or institutions(s):
   - Name of person or parties to receive your child's medical information:
   The information may be disclosed on Children's TherAplay's website, social media, paper and digital publications, press-releases and other web-based platforms. The information may also be disclosed to Children's TherAplay board of directors, volunteers, and donors, including tours taking place during clinic hours of operation.
   - Please indicate where we should mail your child's medical information (or any alternative instructions for delivery): N/A

5. This authorization will expire 60 days from signing, unless an alternative date is indicated: Until such time as the child is no longer receiving services at Children's TherAplay.

6. The purpose of this disclosure is as follows: To allow Children's TherAplay to use the information for promotional, marketing, fundraising, training, and other related purposes. Children's TherAplay will not receive remuneration or payment for any disclosure of my child's protected health information.

7. I understand that I have the right to revoke this Authorization, if the revocation is in writing, at any time by sending a written request to The Children's TherAplay Foundation, 9919 Towne Road, Carmel, IN 46032. I am aware that my revocation will not be effective regarding the uses and disclosures of content by Children's TherAplay made in reliance on this HIPAA Authorization and that have been made prior to receipt of my revocation.

8. I understand that The Children's TherAplay Foundation, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

9. I understand that my child's Protected Health Information that is disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my child's Protected Health Information will no longer be protected by the law.

10. I understand that if I am requested to sign this Authorization by The Children's TherAplay Foundation, Inc., that (i) I will be given a copy of this Authorization; (ii) I may inspect or copy the information to be used or disclosed; and (iii) I may refuse to sign this Authorization.
    By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the disclosure of my child's Protected Health Information in accordance with the terms of this Authorization.

____ ____
Signature of Parent or Guardian Signature of Parent or Guardian

______________ ______________
Date Date

Optional

As a United Way of Central Indiana partner agency, we are required to request the following information.

Clients Served by the Agency

First Name:________________________________ Last Name: ___________________________

Date of Birth:_______________________________ Age: _________________________________

Home Address Street: ____

City:_______________________________________ ZIP Code: ___________________________

County:____________________________________ Preferred Pronouns: ___________________

Gender:_________________________________

Race:
- African-American or Black
- American Indian or Alaskan Native
- Asian
- Caucasian/White
- Native Hawaiian or other Pacific Islander
- Two or more races
- Unknown

Ethnicity:
- Hispanic or Latino
- Non-Hispanic or Latino

Number in Household: ____

Household Income:
- $26,000 and below
- $27,000-$45,000
- $46,000-$65,000
- $66,000-$74,000
- $75,000-$90,000
- $91,000-$100,000
- $100,000 and above

School District Child Attends: ____

School Child Attends: ____

Child's Grade Level:__________________________ Anticipated HS Graduation Year: _________

2022 PATIENT INFORMATION UPDATE

I have reviewed my personal information and deem it to be correct. I understand that I am responsible for updating any changes in my insurance benefits. Starting January 1st, 2022, I acknowledge that $50.00 will be collected towards my deductible providing that I don't have a secondary policy. Additional costs could be due once the claim has been processed by my primary insurance company.

____

Child's name

____

Parent/Guardian Printed name   Date

____

Parent/ Guardian Signature

Thank you!
Please send any required documents to: Children's TherAplay main office, email them to dfisher@childrenstheraplay.org (not your therapist), or fax them to (317) 872-3234 by 6:00 PM on Monday, January 31st, 2022.