ACCESS® Therapy Evaluation Appointment Package Checklist

The ACCESS Evaluation and Resource Center provides comprehensive developmental, psychological and psycho-educational diagnoses and rule-outs for children and youths ages 0-17. Our multi-disciplinary team of professionals has the benefit of regular exposure to children and youths with learning differences in their therapeutic and educational environments. Their knowledge reaches beyond diagnostics to real-world applications and recommendations. ACCESS Evaluation and Resource Center clients may also benefit from enrollment in ACCESS Preschool or ACCESS Academy and/or outpatient therapy services.

A completed ACCESS Therapy Evaluation appointment package contains:

- ACCESS General Information and Insurance Form
- Copy of Insurance Card
- Receipt of Notice of Privacy Practices Written Acknowledgement Form
- Copy of Evaluations and Goals (If Previous Services Were Received)

Please return your completed package to:

Beth Rice, M.A.
Admissions Coordinator
ACCESS
10618 Breckenridge Dr.
Little Rock, AR 72211
beth@accessgroupinc.org
501-217-8600 Phone
501-217-8636 Fax

Once your completed package has been received, we will work to secure any needed prescriptions for the evaluation from your child’s primary care physician and, once any needed prescriptions are received, we can schedule the evaluation. Please don’t hesitate to contact Beth Rice with any questions at beth@accessgroupinc.org or 501-217-8600.
Comprehensive, Multi-Disciplinary Assessments

The ACCESS Evaluation and Resource Center offers comprehensive therapy evaluations for individuals ages birth to 17. Evaluations can include rule-outs and diagnoses for disabilities such as apraxia and sensory integration disorder, as well as testing for speech-language, occupational, physical and developmental delays.

ACCESS Evaluation and Resource Center provides parents with a relatively quick admissions process; plenty of time for parents to speak with our evaluation team therapists regarding diagnostic impressions; and help navigating insurance, state and federal funding processes. Evaluations include an up-to-two-hour diagnostic period, a report and additional testing recommendations, if needed. Initial and yearly evaluations are required for therapy services; ACCESS can accommodate those required evaluations. A physician referral for evaluation is requested by ACCESS and required by some insurance companies. ACCESS will help secure this referral after a parent has contacted us.

General Information
- Individuals Ages Birth-17
- Comprehensive Rule-Outs and Diagnoses for Apraxia, Sensory Integration Disorder and Other Developmental Disorders
- Speech, Physical, Fine/Gross Motor Skill and Developmental Delay Testing
- Insurance Accepted, ARKids A, ARKids B (applied to speech therapy evaluations only), TEFRA and Medicaid Funding Accepted
ACCESS® Developmental and Therapy Evaluation Fees

ACCESS Developmental and Therapy Evaluation fees cover the one-time costs of evaluating clients for either developmental evaluations (adaptive, social-emotional, physical, communications and cognitive development) for younger clients or speech-language, occupational or physical development for clients up to age 17, plus written reports. These costs may be supplemented by insurance coverage. Initial and yearly evaluations are required for therapy services; ACCESS can accommodate those required evaluations.

Optional Followup Developmental/Therapy Treatment Fee Information: ACCESS accepts TEFRA, ARKids First A, ARKids First B (applies to speech therapy only) and Medicaid funding for therapy services. Many children qualify for disability-based and/or income-based funding to offset the cost of therapy. ACCESS also accepts Developmental Day Treatment Clinic Services (DDTCS) funding for ACCESS Preschool. Children who qualify for these services have their ACCESS Preschool tuition payment funded by the state; families with DDTCS funding pay materials fees and aftercare fees only for ACCESS Preschool.
MEDICAL INSURANCE INFORMATION

For therapy clients - Please fill this form out in its entirety and provide copies of the front and back of the insurance cards listed below.  *(The front desk can make copies of your cards if needed)*

Student’s Full Name ____________________________________________ SSN: __________________________

(As shown on Insurance Card)

Parent’s Names ______________________________________________________________

Address:______________________________________________________________________________

Race:  [ ] I-American Indian/Native Alaskan                [ ] A-Asian
       [ ] B-Black or African American                [ ] P-Native Hawaiian or Other Pacific Islander
       [ ] W-White/Caucasian                            [ ] E-Other
       [ ] 7-Declined

Ethnicity: [ ] H-Hispanic or Latino                [ ] N-Not Hispanic or Latino
         [ ] 7-Declined

Language: [ ] Arabic                             [ ] Cantonese
          [ ] Persian                             [ ] Polish
          [ ] English                             [ ] Portuguese
          [ ] French                               [ ] Romanian
          [ ] German                               [ ] Russian
          [ ] Hindi                                [ ] Spanish
          [ ] Italian                               [ ] Tagalog
          [ ] Japanese                             [ ] Ukrainian
          [ ] Korean                                [ ] Urdu
          [ ] Mandarin                              [ ] Vietnamese
          [ ] Other

Primary Insurance Company: ________________________________________________________________

Address ______________________________________________________________________________

Policy Holder ________________________________________________________________ (As shown on Insurance Card)

Policy Holders SSN: ____________________   Date of Birth: __________________

Policy Number: ___________________________ Group Number _________________________

Secondary Insurance Company: ________________________________________________________________

Address ______________________________________________________________________________

Policy Holder ________________________________________________________________ (As shown on Insurance Card)

Policy Holders SSN: ____________________   Date of Birth: __________________

Policy Number ___________________________ Group Number _________________________

ACCESS Group Inc. will file your insurance for you. However, this does not guarantee that your insurance company will pay for the therapy services. You are ultimately responsible for the payment due on all services.

I hereby authorize ACCESS Group Inc. to furnish information to my insurance company concerning the care of my child. I assign all payments for services rendered to my child to the above. I understand that I am ultimately responsible for the payments due on all services.

Parent/Guardian Signature ____________________________ Date ______________________

☐ My child does not receive therapy services.
INSURANCE INFORMATION

For therapy clients only – Please fill this form out in its entirety and provide copies of the front and back of the insurance cards listed below. (The front desk can make copies of your cards if needed)

Student’s Full Proper Name _____________________________________________________
(As shown on Insurance Card)

Parent’s Names ______________________________________________________________

Address ____________________________________________________________________

Primary Insurance:

Insurance Company ___________________________________________________________

Address ____________________________________________________________________

Policy Holder ________________________________________________________________
(As shown on Insurance Card)

Policy Holders Social Security # ____________________ Date of Birth ________________

Policy Number _____________________________ Group Number _____________________

Secondary Insurance:

Insurance Company ___________________________________________________________

Address ____________________________________________________________________

Policy Holder ________________________________________________________________
(As shown on Insurance Card)

Policy Holders Social Security # ____________________ Date of Birth ________________

Policy Number _____________________________ Group Number _____________________

ACCESS Group Inc. will file your insurance for you. However, this does not guarantee that your insurance company will pay for the therapy services. You are ultimately responsible for the payment due on all services.

I hereby authorize ACCESS Group Inc. to furnish information to my insurance company concerning the care of my child. I assign all payments for services rendered to my child to the above. I understand that I am ultimately responsible for the payments due on all services.

____________________________________________________________________________
Parent/Guardian Signature        Date

☐ My child does not receive therapy services.
I, _______________________________, have received a copy of ACCESS Group, Inc.’s
Notice of Privacy Practices.

______________________________   _________________
Signature of Client       Date

______________________________   _________________
Witness, if needed       Date

______________________________   _________________
Signature of Parent/Guardian, if applicable    Date

DOCUMEN TATION OF “GOOD FAITH” EFFORTS
TO OBTAIN WRITTEN ACKNOWLEDGMENT

A written acknowledgment was not obtained from this client because

____  Client refused to sign.

____  Other – Briefly Explain:

______________________________   _________________
Signature of Employee Completing      Date
Documentation of “Good Faith” Efforts Form
ACCESS GROUP, INC.

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 CLIENT OF ACCESS GROUP, INC.)
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

ACCESS Group, Inc. is dedicated to maintaining the privacy of your individually
identifiable health information as protected by law, including the Health Information
Portability and Accountability Act (HIPAA). 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 maintain at ACCESS Group, Inc. concerning your protected health
information (PHI). By federal and state law, 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 PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or
retained by ACCESS Group, Inc.. 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 ACCESS Group, Inc. has created or maintained
in the past, and for any of your records that we may create or maintain in the
future. ACCESS Group, Inc. will post a copy of our current Notice at each facility
in a visible location at all times, and you may request a copy of our most current
Notice at any time.
B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer
ACCESS GROUP, INC.
10618 Breckenridge Drive
Little Rock, AR  72211
501-217-8600

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

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

1. **Treatment.** ACCESS Group, Inc. may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for ACCESS Group, Inc. – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment.** ACCESS Group, Inc. may use and disclose your PHI 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 PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** ACCESS Group, Inc. may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, ACCESS Group, Inc. may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for ACCESS Group, Inc.. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

**OPTIONAL:**

4. **Appointment Reminders.** ACCESS Group, Inc. may use and disclose your PHI to contact you and remind you of an appointment.
OPTIONAL:
5. Treatment Options. ACCESS Group, Inc. may use and disclose your PHI to inform you of potential treatment options or alternatives.

OPTIONAL:
6. Health-Related Benefits and Services. ACCESS Group, Inc. may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
7. Fundraising. We may contact you to raise funds for ACCESS Group, Inc..

OPTIONAL:
8. Release of Information to Family/Friends. ACCESS Group, Inc. may release your PHI 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 take their child to the pediatrician’s office for treatment of a cold. In this example, the babysitter may have access to this child’s medical information.

9. Disclosures Required By Law. ACCESS Group, Inc. will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI 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. ACCESS Group, Inc. may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   
   • maintaining vital records, such as births and deaths
   • reporting child abuse or neglect
   • preventing or controlling disease, injury or disability
   • notifying a person regarding potential exposure to a communicable disease
   • notifying a person regarding a potential risk for spreading or contracting a disease or condition
   • reporting reactions to drugs or problems with products or devices
   • notifying individuals if a product or device they may be using has been recalled
   • notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult 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
   • notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** ACCESS Group, Inc. may disclose your PHI 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.** ACCESS Group, Inc. may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person’s agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - 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)

**OPTIONAL:**

5. **Deceased Patients.** ACCESS Group, Inc. may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**OPTIONAL:**

6. **Organ and Tissue Donation.** ACCESS Group, Inc. may release your PHI to ACCESS Group, Inc.s that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**OPTIONAL:**

7. **Research.** ACCESS Group, Inc. may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the
use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. **Serious Threats to Health or Safety.** ACCESS Group, Inc. may use and disclose your PHI 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 ACCESS Group, Inc. able to help prevent the threat.

9. **Military.** ACCESS Group, Inc. may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** ACCESS Group, Inc. may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** ACCESS Group, Inc. may disclose your PHI 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.

12. **Workers’ Compensation.** ACCESS Group, Inc. may release your PHI for workers’ compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that ACCESS Group, Inc. 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 the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. ACCESS Group, Inc. 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 PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI 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 PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted;
   (b) whether you are requesting to limit ACCESS Group, Inc.’ use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI 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 the Privacy Officer in order to inspect and/or obtain a copy of your PHI. ACCESS Group, Inc. may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. ACCESS Group, Inc. 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 ACCESS Group, Inc.. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. ACCESS Group, Inc. 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 PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by ACCESS Group, Inc., 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 ACCESS Group, Inc. has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in ACCESS Group, Inc. is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. 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 April 14, 2003. The first list you request within a 12-month period is free of charge, but ACCESS Group, Inc. may charge you for additional lists within the same 12-month period. ACCESS Group, Inc. 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 of 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 the Privacy Officer.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with ACCESS Group, Inc. or with the Secretary of the Department of Health and Human Services. To file a complaint with ACCESS Group, Inc., contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. 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.** ACCESS Group, Inc. 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 PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI 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 or our health information privacy policies, please contact the Privacy Officer.