Teri Kozlowski, OTR LLC
Teri Kozlowski OTR and Associates
Pediatric Occupational Therapist

Pediatric Occupational Therapist
S.I.P.T. Certified
NDT Trained in Infants and Pediatrics
301-933-7880

MD License # 01882
Private Practice
Consultation
Fax: 301-933-7911

Dear ____

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) 933-7880, ext.2. Please return forms to:

Teri Kozlowski, OTR LLC
ITS: Developmental Therapy Services, Inc.
10605 Concord Street, Suite 102
Kensington, MD 20895

Sincerely,

Teri Kozlowski, OTR LLC

By:____________________________
Teri Kozlowski OTR

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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I would like to take this opportunity to introduce myself and inform you of our office billing procedures, along with payment options we offer. My name is Jessica Holler, and I am Teri L. Kozlowski's, OTR Office Manager. I am the point of contact for billing and collections needs.

Enclosed is the fee schedule for Teri L. Kozlowski, OTR and payment policy agreement. Please sign and return the credit card/debit card transaction form. Please note that the remittance address for the billing office is as follows and all payments or correspondences regarding billing should be mailed to this address.

Teri L. Kozlowski, OTR
Attn: Jessica Holler
164 West Main St. Ste F
New Market, MD 21774

For your convenience we accept Visa, MasterCard, Discover and American Express Credit Cards as well as Debit cards from your checking account. **WE DO NOT ACCEPT CHECKS.** Credit card/Debit charges will be made on or around the 8th of each month and an itemized statement will be sent to you at that time.

I look forward to working with you. Should you have any questions, please feel free to contact me at (301) 865-9740 or via e-mail at itsdtsbilling@yahoo.com.

Sincerely,

Jessica M Holler,
Billing Manager

Enclosures

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Current Fee Schedule and Payment Policy as of June 1 ,2014

The following is the current Fee Schedule and Payment Policy for services to be provided to your child by Teri Kozlowski, OTR LLC 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 per hour*

Occupational Therapy Full Evaluation - $700
Includes administration, scoring, written analysis and 1 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/School Visit/Home Visit - *$200.00 per Hour*
This fee includes consults such as school observations, telephone consults with related service providers, parent consultation and written reports.

All hourly rates are billed in quarter hour increments.

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Payment for Services

For your convenience, we accept Visa and MasterCard as well as debit from your checking or savings account**. We do not accept checks**. Credit Card and Debit charges will be processed on the eighth day of each month and itemized statements will be sent to you.

Please sign and return the Credit Card/ Debit Transaction Form along with the remainder of the forms. All correspondences regarding billing should be mailed to this address:

Teri Kozlowski, OTR LLC
c/o ITS: Developmental Therapy Services, Inc.
10605 Concord Street
Suite 102
Kensington, MD 20895

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 *treating therapist* at either 301-933-7880, ext. 2 (Teri) or 301-933-5688 (all other therapists).

Appointments that are not cancelled are considered “no-shows”. These appointments will be billed at the full rate.

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Credit Card/ Debit 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 American Express Discover

Card # ______________________________________ Exp Date:__________

Billing Address and Name on the card:

____
____
____

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 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:

Cardholders Signature:__________________________________ Date:________________
Print Name:____
Name of Child: _____________________________________ Phone :________________
*All credit cards will be processed on 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, LLC 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, and are not related to potential insurance coverage. I understand that Teri Kozlowski, LLC 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, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

__________________ ____
Date Signature of parent or legal guardian
Print Name:______________________________

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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 and/or any independent contractor under the foregoing at ITS: Developmental Therapy Services, Inc. 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, LLC, Teri Kozlowski, any of their independent contractors, and ITS: Developmental Therapy Services, Inc. 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

Name: ____

Date of Birth: ____

Mother's Name: ____

Father's Name: ____

Address: ____

Ph number: H:______________ Cell: ________________MW: _________________
FW: ____________________

Email Address: ______________________________

Current School or Program: _______________________________Grade: ______________

Phone #: ________________________Teacher Name: ______________________________

Name of Primary Insurance Company:
____

ID #: ___________________ Group #: _________________Phone #: _________________

Name of Secondary Insurance Company:
____

ID #:____________________ Group #: __________________Phone #:_________________

Please describe your **parental concerns** and **primary referral reasons**:
(Please include any **medications** or **allergies/special diets**)

Briefly describe pertinent medical history such as any **surgeries**, **medical diagnoses** or any **history of seizures** (or attach reports that will summarize the information.):

Describe current health status:

Please briefly describe **developmental** and **therapeutic** history or any **learning challenges** your child has:

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Consent to Release Form

I, ______________________________________ (*print name*) give my permission and consent to Teri Kozlowski, LLC, Teri Kozlowski OTR, 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, ____ give my permission to Teri
(Print name)
Kozlowski OTR and Associates to speak with the above listed professionals regarding my son/daughter ____________________.

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Parental/Consent Form

I, ______________________________________ (*print name*), give my permission toTeri Kozlowski, LLC, Teri Kozlowski OTR, and their consultants (hereinafter, collectively, the "Company") to observe my child (or the child under my care) ____________________, 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____

Print Name:____

Date:____

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Name of child: ________________________________ DOB: __________________
Referred by: ____

School: ____
Address: ____
Telephone: ____
Teacher: ________________________________Telephone: _____________________

Occupational Therapist: ____
Telephone: ____
Address: ____

Physician: ____
Telephone: ____
Address: ____

Speech Pathologist: ____
Telephone: ____
Address: ____

Psychologist/Psychiatrist (circle one):_______________________________________
Telephone: ____
Address: ____

Educational Consultant: ____
Telephone: ____
Address: ____

Optometrist/Ophthalmologist (circle one): ___________________________________
Telephone: ____
Address: ____

Neurologist:____
Telephone:____
Address:____

Teri Kozlowski, OTR, LLC

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: 10/01/2016

Teri Kozlowski, OTR, LLC is required by law to keep your 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 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 health information without your permission for the following reasons:

- **Treatment**. We may share information with doctors and other health care providers who care for you. For example, if your 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 you receive 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 be use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your 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 Health Information May Also Be Used or Shared Without Your Permission for:

- **Abuse and Neglect.** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **As Required by Law.** We will share your 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 information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **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 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 information to report to agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
- **Research**. We may share your 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 privacy, too.
- **Threats to Health and Safety.** Your health information may be shared if it is believed that it will prevent a threat to your 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 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 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 information.** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your 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 health information**. You have the right to see your 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 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 information was used or shared.** You can ask us to tell you when your information was shared and who we shared it with. 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 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 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 Teri Kozlowski OTR, LLC.
- Anyone who is allowed to add health information to your file, including students and other staff
- Any volunteers who may help you while you are in this clinic

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 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 Teri Kozlowski, OTR, LLC.

Teri Kozlowski, OTR, LLC

Acknowledgement That You Have Received Our Privacy Notice

Teri Kozlowski, OTR, LLC is required by law to keep your 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 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 name	Date
______________________________	______________________
Print your name if you are not the patient	Relationship to patient

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Therapist Contact Information

Shannon Elie	301-933-5688	Ext. 1
Julie Mishkin	301-933-5688	Ext. 6
Jenny Post	301-933-5688	Ext. 8
Colette Silver	301-933-5688	Ext. 7
Deborah Victor	301-933-5688	Ext. 4
Julie Schade	202-491-9483	
Susie Stern	301-500-8648	

Services Rendered at:
10605 Concord Street
Suite 102
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 Bldg on Right Across the street from Sunoco. Parking is to the right.