Welcome! Prior to starting services with **READY SET GO THERAPY,** we ask that you to provide us with some information. This information will help us to better understand your child, and to most effectively meet the needs of your child and your family. In this packet, you will also find a description of our services and policies. Enclosed are the following:

- Registration Form
- Notice of Privacy Policies and Procedures
- Privacy Policies and Procedures Receipt and Consent
- Parent Policies
- Service Agreement
- Release of Information
- Allergy Action Plan
- Transportation Release
- Photo Release
- Sensorimotor History
- A Sensory Profile or Sensory Processing Measure Parent Questionnaire, if appropriate. Please answer each question/test item to the best of your ability, as we are unable to score the assessment if any item is left unanswered. This questionnaire should be completed prior to your child's evaluation.

You may keep the Notice of Privacy Policies and Parent Policies and Procedures forms. Please complete the remaining forms, and fax, mail, scan and email, or drop off the forms prior to your child's first appointment at:

350 Gate 5 Road
Sausalito, CA 94965
Fax: (415) 963-4243
info@readysetgotherapy.com

Providing this information as soon as possible prior to your child's session will help us to prepare appropriately for the first meeting with your child. If no one is in the office when dropping off forms, you may leave the forms in the black mailbox facing you after you enter the building. If you have any questions, please call us at (415) 339-8800. We look forward to meeting you!

Registration Form

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

Please complete the following form to provide us with the necessary information to treat your child:

PERSONAL INFORMATION (check if a twin ☐)

Child's Name:_____ Date: _____ Referred by:_____

Birthdate: _____Age: _____ School: _____ Grade:_____ Teacher:_____

Parent name:_____Address:_____

Parent name:_____Address:_____

Other family members in household (include sibling ages); other caregivers (include contact information):

_____

_____

Phone #'s: List name and type (cell/home/work):_____

_____

E-Mail Addresses:_____

MEDICAL INFORMATION

Medical Diagnosis (if applicable):_____ Date given: _____ By (name of professional):_____

Allergies:_____Dietary Restrictions:_____Medications:_____

Please list any known precautions or physical conditions (seizures, heart problem, asthma, muscle/bone disorder):

_____

Person Responsible for Payment:_____ Co-pay $_____Pediatrician:_____

ADDITIONAL INFORMATION

List any additional therapy or services/interventions, and name of providers (current and previous):

_____

_____

Primary Concerns:

1._____

2._____ _____

3._____

Notice of Privacy Policies and Procedures

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

READY SET GO THERAPY, INC, respects the confidentiality of its clients (child and legal parent/caregiver) and will maintain the privacy of your health information by all applicable federal and state laws. Ready Set GO Therapy will implement the following privacy policies and procedures:

Treatment: We may use and disclose your child's health information as part of assessment and intervention procedures. If a non-parent caregiver is present at your child's therapy session, consent is implied to discuss basic components of the treatment session, answer questions, and provide recommendations and/or home program suggestions. If you prefer to limit communication with a non-parent caregiver in your child's session, please let your therapist know. With written consent, we may use and disclose your child's information with other professionals working with your child. If a parent/legal guardian would like Ready Set GO Therapy, Inc. to consult with other caregivers/professionals/persons, he or she shall sign and submit a Release of Information form for that function.

Communication
We send written reports via our secure email system. Day to day communication via email is not secure. If you prefer to communicate via phone, please let your therapist know.

Healthcare Operations
We may use your child's information for appointment reminders (i.e. voice mail, email, reminder cards, post-it notes). We may use and disclose your child's health information to obtain payment for services we provide.
Ready Set GO Therapy, Inc. is a teaching facility. Your child's information may be used for the education of occupational therapy students and members of the community. Students, volunteers, and supplementary staff will sign a confidentiality agreement to adhere to the privacy policies and practices as outlined in this document. The quality of a child's therapy session is of primary importance. Students and volunteers will observe or participate only if this can be done without interfering with a child's session. For educational purposes your child's information may be used without consent, *only* with name and identifying information excluded. Occasionally persons within the community (for example, new parents or related services) may request to visit the facility. These visits will also be scheduled only if it is determined not to interfere with a child's therapy session.

Your Authorization:
You may give us written authorization (Release of Information) to use your child's information or disclose it to anyone for any purpose. If an authorization is provided to us for any individual or entity you may revoke the authorization in writing at any time.

Marketing
We will not use your child's information for marketing purposes without a written release.

Required by Law
We may be required to provide information to law officials under certain circumstances. We are mandatory reporters. We may be obligated to use or disclose your child's information if we believe that your child is a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes.

National Security
We may be obligated to use or disclose your child's information as required for national security: to military authorities or armed forces personnel, to authorized federal officials as required for lawful intelligence, counter-intelligence, and other national security activities, or to correctional institution or law enforcement official, having lawful custody of health information of inmate or patient under certain circumstances.

We reserve the right to change our privacy practices at any time. If we change the privacy practices, we will issue a revised notice of privacy practices. If you wish to obtain an additional current copy of our privacy practices, you may obtain it at any time by contacting Jamie Close or Leigh Burkey at Ready Set GO Therapy, Inc. This Notice takes effect September 1, 2017, and will remain in effect until replaced.

Privacy Policies and Procedures
Receipt and Consent

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

We, _____and_____, acknowledge that we have
Print Names of Legal Parents/Guardians
received and reviewed a copy of **READY SET GO THERAPY, INC.**'s Notice of Privacy Policies and Practices.

We consent to **READY SET GO THERAPY, INC.**'s disclosure of our child's information for treatment/intervention, billing, and healthcare operations according to the terms outlined in the Notice of Privacy Policies and Practices.

Signed,

_____ _____
Signature of Legal Parent/Guardian (1) Date

_____ _____
Printed Name Date

_____ _____
Signature of Legal Parent/Guardian (2) Date

_____ _____
Printed Name Date

==========

For Office Use Only:

Reasonable attempts were made to obtain written acknowledgment of our Notice of Policies and Procedures. However, **READY SET GO THERAPY, INC.** was unable to obtain written consent due to the following:

☐ Individual Refused to Sign
☐ Communication barriers prohibited written exchange
☐ Other:

Explain:_____
_____

Additional Notes:
_____
_____
_____

Parent Policies

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

Payment:

Individual Treatment Sessions
This is inclusive of a 50-minute session, plus 10 minutes for set-up, clean-up, treatment planning, and documentation. Co-payments vary depending on your Kaiser Permanente plan and you should verify your co-payment amount per session with Kaiser Permanente prior to the start of services. You are responsible for co-payments to Ready Set GO Therapy, Inc. and you will be billed monthly.

Other fees
There is a $30.00 fee for returned checks, in addition to any fees charged to us by our financial institution.

Outstanding balances over 60 days are subject to collections, fees, and an interest rate charge of 18% APR.

Cancellations/Holidays
Our therapists block off time to work with your child. Please be respectful of your Therapist's time. Cancel only when it is necessary, and provide as much advance notice as possible.

- **We require a minimum of 24 hours notice for cancellations.**
- Cancellations must be confirmed in writing or by phone. Verbal notice of cancellation must be followed up via phone or email.
- Cancellations made within 4 hours of a session are considered a No-Show. If you have 2 No-Shows, Ready Set GO Therapy, Inc. will contact Kaiser Permanente and therapy services may be discontinued.

Please do cancel your child's session if he/she has a fever or is otherwise known to be contagious. If your child develops a contagious illness and has potentially exposed other children at our facility to the illness (for example conjunctivitis, chickenpox, head lice, or impetigo), please notify Ready Set GO Therapy at once.

Ready Set GO Therapy, Inc. will be closed for most major holidays. Please speak with your therapist regarding specific dates and scheduling.

Change in Insurance
Please inform us immediately to any changes you experience in your Kaiser Permanente plan including and copayment rate changes or changes in primary versus secondary insurance. Failure to inform Ready Set GO Therapy of such changes will be reported to Kaiser Permanente and services may be terminated or placed on hold. You will be responsible for full payment of any services provided in the event that Kaiser Permanente coverage ends.

Payment
Co-payments are due on a monthly basis. Payment options include credit, debit, or check. Cash will also be accepted if exact change is given, as we do not keep cash readily available as change. If payment is not made within three weeks of billed date, Kaiser will be contacted and services may terminated or placed on hold.

Additional Considerations:

At your child's treatment session
Sessions are 50 minutes long with 10 minutes for transition, preparation, and documentation. Therapists have very tight schedules. If there are questions or comments that need to be discussed, the parent may request to have a shortened session with a private conference. Therapists do not have the flexibility to have extended conversations without prior notice during a regular therapy day.

To ensure everyone's safety, please do not allow children onto the mats or other equipment without the direct supervision of a therapist during your child's scheduled therapy session.

In addition, for the safety of your child, Ready Set GO Therapy, Inc. asks that you are prompt in picking up your child at the end of his or her 50-minute session. Ready Set GO Therapy, Inc. is not responsible for supervising your child after the session has ended. If anyone other than the parent will be picking up your child, please sign a Transportation Release form to be kept on file, or notify your therapist in writing. We cannot accommodate children who are dropped off early for therapy sessions. Please make sure your child is supervised at all times prior to and after the therapy appointment.

Attire
Clothing that is well fitted to the child's body, casual (active wear), and seasonable attire will be appropriate. Your child may be invited to participate in messy play.

Allergic Reactions
We require an Allergy Action Plan on file for all children with allergies that may require immediate treatment. Please make sure to alert your therapist if your child has such an allergy and complete the Food Allergy Action Plan Form included in your welcome packet.

Disaster Preparedness
In the case of evacuation due to a natural disaster or emergency, our established nearby meeting place is across the street, in front of Anchorage Restaurant. Our established meeting place if this location is not safe is at the Molly Stone tables, situated directly between Molly Stones and the USPS.

Discontinuing Services
The decision to discontinue services should be a collaborative decision between Kaiser Permanente, the family and the therapist, and typically occurs once a child's needs are able to be met through an established home program and/or other services within the community. If you decide to discontinue services, or are unable to continue sessions at your child's current time, a 2-week notice to discontinue is requested.

Right to Refuse or Discontinue Services

Interpretation, recommendations, and treatment plans are based, in part, on the history and information that you provide Ready Set GO Therapy, Inc. If information about your child's medical/educational history, interventions, and needs are withheld, misrepresented, altered, or omitted, Ready Set GO Therapy, Inc. reserves the right to terminate the services. Kaiser will be contacted due to non-payment of services, aggressive behavior, lack of progress, lack of cooperation, or a poor match between the needs of the family and skills of the therapist.

Waiting List

If we are unable to accommodate your child for intervention on a regular basis at a time that works for your family's schedule, you may opt to put your child on a waiting list for services. After completing an initial phone consultation to discuss the presenting areas of concern, informational materials will be sent immediately about the clinic and services that we offer. We understand that a timely response is important and will do our best to respond to your request as soon as possible.

Families will be contacted in the order their request was received, and based on individual availability. Flexibility is important. If a time is available that you cannot accommodate, the next person on the list will be contacted. You will remain at the top of the list for the next available time.

Therapists

Our therapists are independent business entities who rent space from us or with whom we establish contracts. We hand select Occupational Therapists through an intensive application and hiring process and we have complete confidence that each therapist will uphold our high standard of practice.

Service Agreement For Occupational Therapy Intervention/Treatment

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

I have requested occupational therapy services for my child, _____,
print child's name

Movement, moving equipment, as well as physical manipulation, are integral to our therapy interventions. While reasonable measures will be taken to avoid injury, I recognize that injuries can occur. Exposed skin and skin-to-skin contact may also occur with provision of services. ☐ Initial ☐ Initial

I understand that I am responsible for my co-payment to Ready Set GO Therapy, Inc. for ongoing individual treatment sessions inclusive of a 50 minute session and 10 minutes for set-up, clean-up, treatment-planning and documentation. Cancellations must be made by phone or in writing, and 24-hour advance notice is required. If there are 2 no shows, Ready Set GO Therapy Inc. will contact Kaiser Permanente and therapy services may be terminated. I understand that I will be billed monthly for co-payments. Charges are non-negotiable as agreed upon in service agreement. If payment is not made within three weeks of billed date, your child will no longer receive services until the account is up to date. I understand that there is a $30.00 fee in addition to any bank fees, if my check is returned unpaid by my financial institution, and that outstanding balances over 60 days are subject to collections, fees, and an interest rate charge of 18% APR. ☐ Initial ☐ Initial

I confirm that I have received and reviewed the Parent Policies and Procedures and agree to adhere to the terms stated.

_____	_____	_____	_____
Signature of Legal Guardian (1)	Date	Signature of Legal Guardian (2)	Date
_____	_____	_____	_____
Print name	Relationship	Print name	Relationship

Release of Information

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

I hereby authorize the exchange of medical, psychosocial, educational, and developmental

information regarding _____ _____
Print Child's Name Date of Birth

Between: **READY SET GO THERAPY, INC.**
350 Gate Five Road
Sausalito, CA 94965
415-339-8800
info@readysetgotherapy.com

And:
(Please list all applicable)

_____	_____	_____
Name	Relationship	Contact Information
_____	_____	_____
Name	Relationship	Contact Information
_____	_____	_____
Name	Relationship	Contact Information
_____	_____	_____
Name	Relationship	Contact Information

This consent is valid and in effect for two years, unless written request to renew or withdraw this form is provided.

Authorized by:

Parent Name (print)_____

Signature_____ Date_____

Allergy Action Plan

Emergency Care Plan

Name: _____ **D.O.B.:** ____/__/____

Allergy to: _____

Weight: _____lbs. **Asthma:** Yes (higher risk for a severe reaction) No

Extremely reactive to the following: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* present.

☐ If checked, give epinephrine immediately if the allergen was *definitely* present, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand_____ and dose_____):

Antihistamine (brand _____and dose_____):

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

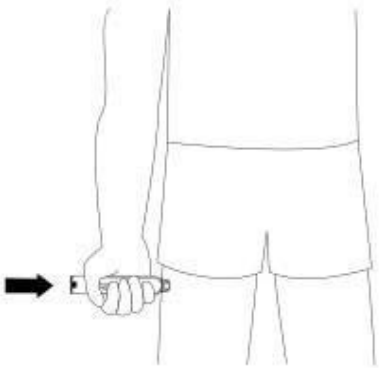
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER **Form provided courtesy of Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013**

EpiPen® (epinephrine) Auto-Injector Directions

- **First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

- **Hold orange tip near outer thigh (always apply to thigh)**



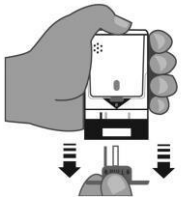
- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.**

Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

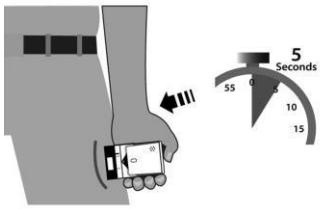
EPIPEN 2-PAK® EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.



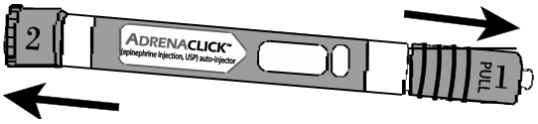
Pull off RED safety guard.



Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q™
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Allergy Action Plan.

Contacts

Call 911 • Rescue squad: (____) _____-_____ Doctor: _____ Phone: (____) _____-_____

Parent/Guardian: _____ Phone: (____) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (____) _____-_____

Name/Relationship: _____ Phone: (____) _____-_____

Form provided courtesy of the Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013

Transportation Release

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

I give permission for my child, _____,
print child's name

to leave occupational therapy with the follow individuals (please list names of any relatives, sitters, or friends that you would like to authorize to transport your child):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Authorized by:

_____ _____
Signature of parent/legal guardian Date

_____
Print name

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

Photo Release Form

**THIS FORM IS OPTIONAL.*

I give my permission for **READY SET GO THERAPY, INC.** to use images or video of my child or family

_____ for promotional and/or educational purposes.

All photos or videos used will be taken during scheduled treatment sessions. Photos or videos may be used in print materials, presentations, and on the **READY SET GO THERAPY, INC.** website. I understand that these photos or video will be used for promotional and/or educational purposes only.

_____
Name of Parent or Guardian

_____
Signature of Parent or Guardian

Sensorimotor History

READY SET GO THERAPY
350 Gate 5 Road
Sausalito, CA 94965
Phone 415-339-8800
Fax 415-963-4243
info@readysetgotherapy.com

Please complete the following form to help us gain more information to determine the needs of your child:

Child's Name:_____ Date: _____

Person completing form:_____ Relationship to child:_____

Significant medical history including major illness, accidents or incidents, and date of occurrence:

_____

_____

Developmental History

Birth History

Circle All Applicable: Full term Premature Breech Caesarian Difficult labor Forceps Suction

Birth weight:_____

List any complications or other significant information regarding prenatal period/birth. *This information is important in our understanding of how to best approach intervention for your child, as it can impact sensory and motor development:*

_____

_____

Developmental Milestones

Circle All Applicable: Reflux/GI issues Colic Difficulty Sleeping Limited Self-Soothing Torticollis

Give approximate *age of mastery*, if known:

Rolling over:_____1-2 words:_____Using Sentences:_____

Potty Training: Day: _____ Night:_____

Establishment of Regular Sleep/Wake Cycles:_____ Falling Asleep Independently: _____

Did your child master a smooth and symmetrical crawl for a minimum of 1-2 months? Yes / No

If no, please describe:_____

Do you notice any asymmetry in your child? Yes / No Describe:_____

Does your child sleep well? Yes / No Describe:_____

About Your Child:

Please describe your child's morning and evening routines (including level of assistance required):

_____

_____

_____

_____

_____

What is your child's level of independence and/or ability to tolerate participation in dressing/undressing and completing self-care and grooming tasks (brushing teeth, bathing, washing/brushing hair):

_____

_____

_____

_____

_____

Please describe mealtimes with your child. Include all relevant information, including where your child eats, whether he/she eat meals with the rest of the family, and level of assistance required for self-feeding:

_____

_____

_____

_____

_____

Please describe the level of safety awareness your child exhibits at home and within the community:

_____

_____

_____

_____

Please list any concerns you have (if any) related to your child's social skills and interactions:

_____

_____

_____

Is your child able to play independently? What are your child's favorite activities?

_____

_____

_____

What things does your child seem to fear or avoid, if any?

_____

_____

Please list any questions or concerns that you would hope this screening/evaluation would answer?

_____

_____

Do you have any tips or strategies to suggest when working with your child?

_____

_____

What are your child's greatest strengths?

_____

_____

Is there anything else that you would like for us to know about your child?

_____

_____

_____

_____

_____