Chris Zombek BSDH, COM®
Email: chriszombek@innovativemyo.com
Please email filled out forms 1 week prior to appointment.
Phone: 410-746-4887

Patient General Information

Parents First and Last Name

Patient First Name

Patient Last Name

Parent not living with Patient

Address, City, State, Zip

E-Mail Addresses

Father:	Mother:	Patient:

Phone

Father: O Work O Cell	Mother: O Work O Cell	Patient: O Work O Cell

Phone: Best number to reach incase issue with existing appointment or appointment coming up: _____ Is text message ok? O Yes O No

Emergency point of contact: Name: _____ Phone: _____

DOB: _____ Age: _____ Sex O Male O Female

Who should we thank for the referral? _____
Medical Doctor: Name _____
Address _____ Phone _____
Does Patient have IEP? Year _____ Diagnosis_____

Orthodontist: Name _____
Address _____ Phone _____

Dentist: Name _____
Address _____ Phone _____

ENT: Name _____
Address _____ Phone _____

Allergist: Name _____
Address _____ Phone _____

Speech Pathologist: Name _____
Address _____ Phone _____

Chris Zombek BSDH, COM®
Innovative Myo Therapy
Permission for Use of Information

Permission for Exchange of Information

I give permission to exchange medical information, either written, electronically, or by phone, between my providers of medical and therapeutic services (or those of my child), as well as insurance providers. I understand that the purpose of this exchange is to allow for coordinated services between these providers

Name of Patient (printed) _____ Date _____

Patient or Caregiver (Signature) _____ Date _____

Permission to Use Files for Research, Presentation, Publication for Innovative Myo Therapy

I give my permission for use of photographs, videos and records made in the process of examination and treatment, to be used for the purposes of (check all that apply)

- ☐ Research
- ☐ Education, continuing education courses, presentation for educational purposes
- ☐ Publication on Innovative Myofunctional Therapy of Maryland
- ☐ Professional journals

Signed _____ Date_____

SPEECH THERAPY DISCLAIMER

In this practice, **Innovative Myo Therapy** is not a speech therapist and does not make claims to correct speech.
Orofacial myology applies techniques which bring muscles of the face, tongue, and lips into balance so, that they may produce improved articulation. In some cases, a referral will be made for traditional therapy after the muscles respond to our methods of exercise. However, unless the muscles are in proper function a speech program cannot be achieved.
The optimal treatment plan is based on the differential diagnosis by the referral source and the personal wants and needs of the client.

Signature_____ Date_____

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Agreement and understanding of therapy with Innovative Myo Therapy

- **I reserve the right to terminate service: if I observe there is any kind of issue that impedes the airway/nasal breathing such as: tonsils, tongue ties, adenoid/turbinate's, and allergies. If the parent care giver or patient will not have the issue taken care. These things will not allow progression of therapy. Lastly, if there is noncompliance with exercises which will not allow for progress.**
- **It must be noted that successful completion of the myofunctional therapy program is dependent upon patient desire, good attitude and self-discipline. Parental involvement and encouragement are important and necessary. Only the dedicated participant and cooperation of the patient can guarantee effective swallowing and resting posture results. I give you my promise I will show up and give 100%. There will be no refunds for therapy because I guarantee if you put into it you will get results.**
  _____Initial

- DAILY practice of the exercises is important! Please make time in your schedule to focus on your "homework". Some exercises will be mastered in the first week. Others are designed to take a few weeks.
- Practice exercises a minimum of 2-3 times a day, **7** days a week. Some are incorporated in daily routine.
- Consistency is important! I understand that life is busy. I ask that you make every effort to come weekly. Sometimes Face time, Doxy.me, Skype (teletherapy), and Marco Polo (video) to replace session in person may be available decided by therapist and circumstance.
- ALWAYS use your mirror when doing exercises.
- **I prefer to schedule a "set time" for each client's weekly to start and may go to bi-weekly sessions. Think of it as a scheduled music lesson or sports practice. Sometimes, other activities must be put on hold for a season so you can focus on your oral health! A few months of therapy can lead to a lifetime of positive change! YOU GET OUT OF IT WHAT YOU PUT INTO IT!!!!**
- Choose a quiet place where you can focus on your daily exercises. Try to avoid distractions.
- I understand that childcare for other siblings can be difficult to arrange. It is preferred to only have the client and parent present for therapy sessions. I ask that if you MUST bring siblings to an appointment, that they are quiet and do not cause distraction.
- In preparation for your first therapy session, please buy a stand-up mirror, small squirt bottle. I will provide the other necessary tools for therapy depending on therapy delivery there may be a shipping charge. Because supplies are very expensive only one replacement will be given if lost with the exception of the coloplast after the first package the replacement will be $4.00.
- Sometimes the Myobrace Trainer or the Myo Munchee is use and other devices this will be an additional cost to parent or patient because it is an addition cost to therapist. Therapist will work with parent prior to charging. Innovative Myo works very hard to keep cost down but, sometimes it is necessary to include props.
- The number of sessions needed varies greatly, depending on the client's individual case as well as their participation and cooperation in the therapy program.

HOURS: Wednesday new patient evaluations: 1-5 pm. Thursdays: 1-6 pm for therapy some other days may be added as needed if possible (discretion of therapist). For any questions or concerns you can reach Chris Zombek directly at: 410-746-4887 or chriszombek@innovativemyo.com

Parent signature _____ Date _____

Patient signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04-01-14, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Our office only uses the necessary personal health information to perform our duties.

Your Authorization: We use your health information for treatment, payment or healthcare operations. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-Related Services: We will not use your health information for marketing communications without your written authorization.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or

other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiners. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal official's health information required.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information.) You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request an alternative format it will be sent to you within 21 business days after receiving written request.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 3 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information, (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. **We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the:**

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Contact Officer: Chris Zombek Phone (410)746-4887

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

I,_____ _____, have received a copy of this Office's Notice of Privacy Practices.

Signature _____ Date _____

May we have your permission to email you? O Yes O No
May we leave a voice mail on your cell phone? O Yes O No
May we leave a message on your home phone number? O Yes O No

Please list any addition persons in which you will allow us to share your information.

_____

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Financial Agreement/Contract

Commitment Agreement:
The success of the process of correcting the orofacial myofunctional disorder is dependent on attendance at agreed upon therapy sessions, daily exercises two or three times a day (and encouragement/supervision in the case of a child or patient mature level or cognitive ability). The total length of the treatment depends on severity of problem and cooperation of patient. **No refunds for therapy because my promise to you is to show up 100%**

Cancellation Policy: This policy requires at least 48-hour notice should you need to cancel an appointment. If you give less than 48-hour notice or fail to appear for your appointment, you will be charged a $75 full therapy appointment for cancellation/no show fee. If you are sick or there is a true emergency these would be the only valid excuses. This does include a full session of Marco Polo, Teletherapy which includes Skype, FT, Doxy.me and Zoom. When inclement weather therapist will do therapy via Teletherapy so no need to cancel.

New Patient Evaluation/Therapy Supplies $347 Upcharge of 3% if credit card used.

Active Therapy Sessions: $75.00 per lesson plus upcharge of 3% if credit card used. Innovative Myo requires responsible party to pay for **four visits making payment $300.00 plus upcharge of 3% if credit card used due to admin time and charge to therapist.** Whichever visits not used and that are not planned to be used during that month and talked about between therapist and parent or patient will not count as a session so it will still be available.
Marco Polo, Skype, FT and Zoom, any Teletherapy with a treatment plan will be charged just like a normal in person session. For Marco Polo: therapist will leave a video with examples of exercises to be done and patient will leave a video back demoing the exercise and therapist will critique if needed with another video. A treatment plan will be emailed. Marco Polo used with habit program patient is to leave a video two times a day morning, and before bed for the first week stating how they did that day with placing their barriers and not doing the habit. (habit video will not count as a session) This excludes no shows and non-emergency missed appointments. Supplies needing to be sent are will incur shipping cost.

Insurance: This practice does not accept or file for insurance assignment. Payment is due at the beginning of the four sessions and at the time of therapy appointment. You will be provided with a invoice. Again no refunds for therapy provided, my promise is to show up 100%.

Payment Methods: Cash, Check, Health Savings Card, PayPal, Credit Card Mastercard or Visa, Zelle and Venmo (direct pay to bank) (Do not except Discover/American Express) Upcharge of 3% in addition to therapy when credit card used.

_____Initial

_____ Agrees to pay Chris Zombek, Certified Orofacial Myologist of Innovative Myo Therapy in the manner and on the dates agreed upon.

Signature _____Date_____
(For agreement above)

On File Credit card information:

- ○ Mastercard ○ Visa ○ HSA

Card Number _____ Expiration Date _____

Security code on back of card _____

Card Member Signature: _____

This signature verifies that this card may be charged for payment of services when no other payment has been received.

Any unpaid account shall be increased three percent each month beginning 30 days following the date payment was due. Any remaining amount due, including any unpaid charges previously made, shall be increased at the same rate on the first day of each succeeding month until paid. If it becomes necessary to seek legal assistance for the outstanding balance of this account. In addition, no new appointments will be made unless previous appointments are paid for.