GEORGIA COLLEGE
GEORGIA'S PUBLIC LIBERAL ARTS UNIVERSITY

THE MUSIC THERAPY CLINIC OF GEORGIA COLLEGE

Welcome and thank you for choosing the Music Therapy Clinic of Georgia College! It is our mission to support and enrich the lives of individuals and groups in the central Georgia area through music therapy services and community music experiences.

We offer individual and group services at our on-campus clinic, within community partners facilities, in client homes, and through telehealth. Our on-campus clinic is located on the first floor of the Health Sciences Building on the campus of Georgia College & State University and hosts equipment and instruments to accommodate various needs, such as adaptive technology and a sensory space containing bean bags, floor mats, bubble tube, and a vibrotactile Somatron chair.

All our services are provided by professionally trained, state-licensed, and board-certified music therapists. However, as a university teaching clinic, it is important to note that music therapy students and interns may be present during session to observe and/or assist as part of their clinical training experience. If you have questions or concerns about who is providing services, please feel free to discuss with us.

We provide an initial music therapy assessment free of charge and offer individual sessions for $35/half hour or $75/hour. The assessment session, along with the written evaluation, will assist our recommendations of focus for treatment, including measurable music therapy goals and objectives.

Within in our paperwork you will find the new client information form and consent to treat/medical releases. Please feel free to ask any questions!

Additionally, the following documents are not required but would be beneficial towards treatment planning:

- Recent OT/ST/PT/Psychological evaluations within the past year
- Recent IEP goals (if applicable)
- Any other pertinent paperwork that describes level of need that you wish to share

Please note that this form MUST be received prior to the initial assessment. It may be emailed to mt.clinic@gcsu.edu , faxed, or mailed to our clinic. If the form is not received prior to your first appointment, we ask that you arrive 15 minutes early in order to complete your paperwork. We look forward to working with you!

Thank you,

Erin Kelly, LPMT, MT-BC
Music Therapy Clinic Coordinator

The Music Therapy Clinic of Georgia College
Department of Music, College of Arts & Sciences
200 N. Wilkinson St., Health Sciences Building
Campus Box 067, GCSU, Milledgeville, GA 31061
Phone: 478-445-8579 Fax: 478-445-4532
https://www.gcsu.edu/artsandsciences/music/music-therapy-clinic

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NEW CLIENT INFORMATION FORM – UNDER 18

Name:_____ Date of Birth: _____

Year in school *(if applicable):* _____

Gender *(check one)*: Male __ Female __ Non-binary__ Prefer not to answer __

Parent/Guardian Names *(if applicable):* _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone Number: (___) ____-_____ Cell Phone Number: (___) ____-_____

Email: _____

Preferred method of communication *(check one):* Email __ Home Phone__ Cell Phone__

Diagnoses *(if known)*:_____

How did you hear about us? _____

What skills or areas of need would you like to be addressed through music therapy?_____

_____

_____

Are there any physical, behavioral or sensory conditions or considerations?_____

_____

_____

1st Preferred session schedule *(check one)*:
Mon __ Tues __ Wed __ Thurs __ Fri __ Time: _____Other: _____

2nd Preferred session schedule *(check one)*:
Mon __ Tues __ Wed __ Thurs __ Fri __ Time: _____Other: _____

* *Sessions are ½ or 1 hour depending upon need*

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FAMILY BACKGROUND

Mother's Name: _____ DOB _____ Occupation: _____

Father's Name: _____ DOB _____ Occupation: _____

Marital Status *(check one)*: Single __ Married __ Divorced __ Separated __ Widowed __

Languages spoken at home: _____ Religious Preference: _____

Is client adopted? *(check one)*: Y __ N __

Adoption background:_____

_____

MEDICAL INFORMATION

Primary Physician: _____

Physician's Phone and Address: _____

Other doctors, specialists and therapists who are involved in client care:

Name	Specialty	Phone Number	How Often Seen

Current Medications: _____

_____

Current Allergies: _____

_____

Other pertinent medical conditions: _____

_____

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EDUCATION INFORMATION

Is client currently enrolled in school *(check one)*? Yes __ No __

If yes, where and days attended? _____

Does client receive any services through the school *(check one)*? Yes __ No __

If yes, what services? _____

Does client have a current Individualized Education Plan (IEP or IFSP) *(check one)*? Yes __ No __

Date of last review: _____

Has client graduated from high school *(check one)*? Yes __ No __ If "Yes", date of graduation: _____

MUSIC HISTORY/PREFERENCES

What are the client's favorite songs, artists or genre of music? _____

_____

Has the client had any previous music experiences *(check one)*? Yes __ No __

If yes, please describe: _____

_____

Has the client ever received music therapy services before *(check one)*? Yes __ No __

If yes, where and when? _____

Does client have a preference or interest in a specific instrument *(check one)*:? Yes __ No __

If yes, please describe: _____

_____

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CLIENT PREFERENCES

What are the client's favorite toys/activities/hobbies/interests? _____

_____

What is the client's favorite TV shows, movies, and/or video games? _____

_____

Is the client enrolled in any community activities (music class, play group, etc.) _____

_____

Are there any other interests not otherwise specified? _____

_____

CONSENT FOR SERVICES

I, _____*(client or guardian),* consent for The Music Therapy Clinic of Georgia College to provide, _____ *(client name)*, with music therapy services. I consent to care and treatment falling under the practice guideline of the American Music Therapy Association and the State of Georgia.

I acknowledge that there is always a risk of injury with any therapy involving physical activities and equipment. The Music Therapy Clinic of Georgia College is not responsible for any injury associated with equipment use when your child is not with a treating therapist. You are responsible for making your therapist aware of any changes to your child's physical or mental condition. The Music Therapy Clinic of Georgia College is a teaching facility and supervised students and interns may participate, co-lead and/or lead during treatment under the direct supervision of a licensed and board certified music therapist. Prospective students and donors may also be present for observational purposes.

_____

Printed Name Relationship to Client

_____

Client or Guardian Signature Date

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PERMISSION FOR EXCHANGE OF INFORMATION

I authorize The Music Therapy Clinic of Georgia College to release necessary and pertinent medical information to physicians, case managers and other therapists as needed for my child, _____.

Approved information may be exchanged with the following people *directly* related to my child's care

(check all that apply):

__ Other therapists, including but not limited to Speech, Physical and Occupational Therapists

__ School Name: _____

__ Please list any other's: _____

Approved information includes written documents and/or verbal discussion.

_____

Printed Name | Relationship to Client

_____

Client or Guardian Signature *(if under 18)* | Date

ATTENDANCE POLICY

We require a 24-hour notice for cancellations. If your child misses 3 consecutive weeks of therapy, we will make every attempt to hold that slot but cannot guarantee this with an extended absence. The Music Therapy Clinic of Georgia College strives to meet the scheduling needs of each family. If your therapy time does not work for you, please let us know. We know that sickness occurs; therefore, if you think your child is sick the night before, please call us and give us notice so that we may plan accordingly, and/or contact a family who is on standby for a make-up session or on a waiting list for an evaluation for services. The Board of Health considers the following signs to indicate communicable disease/illness: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red or running eyes. Please be sure your child is symptom free for 24 hours before resuming therapy. Please note that if you bring your child to therapy and he/she exhibits any of the above symptoms, it is at the therapist's discretion to send them home in order to protect themselves and our other clients from infectious illness.

_____

Printed Name | Relationship to Client

_____

Client or Guardian Signature *(if under 18)* | Date

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CONSENT FOR AUDIO/VISUAL RELEASE

I _____ *(Parent or Legal Guardian)* give permission for _____ *(Name of Child)* to be audio or video taped by the therapists at The Music Therapy Clinic of Georgia College. These audio or video taped sessions will be used for educational and training purposes only (i.e., clinical supervision, conference presentations). At no time will your child's full name be spoken on the tapes and your child's full identity will remain confidential. These tapes may be maintained in a locked facility.

If you do not give permission, then leave the above blank and initial the following:

_____I decline the taking of audio/visual material

_____

Printed Name | Relationship to Client

_____

Client or Guardian Signature *(if under 18)* | Date

CONSENT FOR PHOTOGRAPHIC RELEASE

I _____ *(Parent or Legal Guardian)* give permission for _____ *(Name of Child)* to be photographed by the therapists at The Music Therapy Clinic of Georgia College. These photographs will be used for educational and training purposes (i.e., clinical supervision, conference presentations), and may be used by The Music Therapy Clinic of Georgia College for advertisement purposes (i.e., website, brochures, newspapers).

If you do not give permission, then leave the above blank and initial the following:

_____I decline the taking of photographs

_____

Printed Name | Relationship to Client

_____

Client or Guardian Signature *(if under 18)* | Date

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NOTICE OF PRIVACY PRACTICES:
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the Music Therapy Clinic of Georgia College. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting *478-445-2647.* If you have any questions about our *Notice of Privacy Practices*, please contact:

The Music Therapy Clinic of Georgia College
200 N. Wilkinson St., Campus Box 067
GCSU, Milledgeville, GA 31061
478-445-8579

I acknowledge receipt of the *Notice of Privacy Practices* of the Music Therapy Clinic of Georgia College.

_____
Client's Name

_____
Printed Name *(if not client)* Relationship to Client *(if applicable)*

_____
Client or Guardian signature *(if under 18)* Date

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Client's Name:_____

Reasons why the acknowledgment was not obtained:

Client refused to sign this acknowledgement even though the client was asked to do so and the client was given the Notice of Privacy Practices

Other:_____

_____
Signature of Provider Representative Date

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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 PATIENT OF THIS PRACTICE) 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
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). 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 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 IIHI Your privacy rights in your IIHI Our obligations concerning the use and disclosure of your IIHI The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. 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 our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: The Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

D. USE AND DISCLOSURE OF YOUR IIHI 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. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of: i. Reporting child abuse or neglect ii. Preventing or controlling injury or disability iii. Notifying individuals if a product or device they may be using has been recalled iv. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a 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
2. Health Oversight Activities. Our practice may disclose your IIHI 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. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. Our relationship with you does not confer any doctor/patient or similar privilege against disclosure.
4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official: i. Regarding a crime violation in certain situations, if we are unable to obtain the person's agreement ii. Concerning a death we believe has resulted from criminal conduct iii. Regarding criminal conduct at our office or at the individuals residence during the treatment iv. In response to a warrant, summons, court order, subpoena or similar legal process v. To identify/locate a suspect, material witness, fugitive or missing person vi. 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)
5. Deceased Patients. Our practice may release IIHI if requested by a government official.
6. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being

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used only for the research and (ii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researchers agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI 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 organization able to help prevent the threat.
8. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities).
9. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. Inmates. Our practice may disclose your IIHI 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
11. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.
12. Parent or legal guardian or other disclosed person. We may disclose information to any other parent or legal guardian of the patient, or to the following person(s) who you are specifically designating to receive this information:
13. Any other person/organization who you may authorize us to provide information to, if that authorization is in writing and is dated & signed by you.
14. Your primary care and/or your referring physician.

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

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have additional tests such as MRI, and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write an evaluation or we may disclose your IIHI to an Occupational Therapist (OT), Speech Language Pathologist (SLP), or Physical Therapist (PT) if requested. Many of the people who work for our practice – including, but not limited to, our OTs, PTs, and SLPs – may use or disclose your IIHI in order to treat you or to assist others in your treatment, Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. Payment. Our practice may use and disclose your IIHI 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 IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. Health Business Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. Health-Related benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
6. Release of Information to Family/Friends. Our practice may release your IIHI 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 be with the child during treatment. In this example, the babysitter may have access to this child's information.
7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

E. YOUR RIGHTS REGARDING YOUR IIHI You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice 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 Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

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2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI 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 IIHI, you must make your request in writing to The Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061
3. Your request must describe in a clear and concise fashion: The information you wish restricted: Whether you are requesting to limit our practice's use, disclosure or both; and to whom you want the limits to apply.
4. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI 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 Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice 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.
5. 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 our practice. To request an amendment, your request in writing and submitted to The Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 3106. You must provide us with a reason that supports your request for amendment. Our practice 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 IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
6. 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 our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, an MT sharing information with another MT in the practice; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to The Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061. 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 November 1st, 2006. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
7. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice or 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 Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061.
Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact The Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061. 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. Our practice 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 IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI 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 of our health information privacy policies, please contact The Music Therapy Clinic of Georgia College, 200 N. Wilkinson St., Campus Box 067, GCSU, Milledgeville, GA 31061.

Effective Date of this notice: August 15, 2022

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CLIENT FAQS ABOUT THE HIPAA NOTICE OF PRIVACY PRACTICES

1) What does HIPAA stand for?
HIPAA is an acronym for Health Insurance Portability & Accountability Act which was passed by Congress in 1996 and effective as of April 14, 2003.

2) Why should I sign now?
Signing now simply lets us know you received the HIPAA Notice of Privacy Practices. Of course you can choose not to sign.

3) What happens if I don't sign this acknowledgement form?
First, you need to know we will provide you timely care and treatment whether or not you sign the form. Second, if you choose not to sign the form, we will note your choice on the bottom of the acknowledgement form and hope you take a copy of the Notice.

4) Is my signature just acknowledging receipt of this notice?
Yes. By signing this acknowledgement form we then can show the Department of Health & Human Services that we are complying with one of the major rules of HIPAA to make sure we give every client the opportunity to have our Notice.

5) Why is this notice so long compared to the ones I received from my financial institution or my credit card company(ies) or my life insurance company?
Those companies are subject to a different set of privacy rules under the Graham/Leach Act while all healthcare organizations are subject to HIPAA.

6) Is this HIPAA Notice and acknowledgement form only for the Music Therapy Clinic of Georgia College?
Yes; however, all healthcare organizations such as hospitals, physician offices, urgent care centers, outpatient surgery centers, and home care or hospice care services are subject to HIPAA. These other organizations will have their own Notice and acknowledgement form you may sign when you receive services from them.

7) After I sign this acknowledgement form, then what happens?
We will place your form in your record.

8) What am I going to be paying out because of signing?
Signing our HIPAA Privacy Notice acknowledgement form has **NO** bearing on your current payment arrangements.

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