aMAYZing Kids: Express Registration Date:

1. **PERSONAL INFO: *all information is required to bill insurance***

Child's Full Name: _____________________________ DOB: _________ Circle One: M or F Diagnosis: _______

Insurance: ____________________________ Member ID: _________________ Effective start date: ________

Primary Physician: ______________________________________ Dr. Phone #: ____________________

Guardian's Name: __________________________________ DOB: __________ Preferred #: ________________

Guardian's Name: __________________________________ DOB: __________ Preferred #: ________________

Address: ______________________________ City: ____________________ State: _____ Zip Code: ___________

Email: __________________________________ Legal Custody/Guardianship: __Shared __Other:_____________

2. **PAYMENT INFO:** **I am paying today by….** Insurance: **REQUIRED PRIOR TO 1st APPOINTMENT:**
(You will need to call the phone number on the back of insurance card)

Company name: aMAYZing Kids or Hailey Mayz Foundation NPI: 1023309390 Tax ID: 80-0459455

My deductible is: ________________ Deductible met? Y or N

My copay ________ or co-insurance is: ____________

Allowed # of visits: ____________ Amount Used: _________

Pre-Authorization Required: ________________________

Any exclusions for SP/OT/PT: ____

__ Please bill my insurance directly. I will provide necessary information. I understand verification of benefits is not a guarantee of payment, claims denied by insurance will be patient responsibility.

__ I have secondary insurance: ____

__ I'll get reimbursement on my own and will be paying the entire bill at the time of service.

REPRESENTATIVE NAME: _______________________ REFERENCE #: ________________________________

3. **CHILD'S INFO:**

Are there any precautions the therapist should be aware of when working with your child? If yes, please explain:

What is your primary concern?

In 3-6 months it would be aMAYZing if my child could…

Full term birth? Y or N

If no, weeks premature: _____

Complications with labor or delivery? Y or N

If yes, please explain:

Allergies: ___Peanuts ___Dairy ____Fruit ___Latex
___Other: ___________________

Other services? ____Neurologist ____Orthopedist
____GI/Nutrition ____ABA Therapist ____OT/PT/SP Services

REFERRAL INFO: How did you first hear about aMAYZing Kids?

__Friend/Family __Current Patient __Advertisement

__Internet __Insurance __Doctor(Name:________________)

__Other:________________________

4. **PARENT PERMISSION:** (please initial each item and sign below)

Initial: ________Authorization of services: I give my consent for my child to receive services by aMAYZing Kids' therapists in the clinic.

Initial: ________PHOTO CONSENT: I hearby authorize aMAYZing Kids to photograph/ videotape my child for the purpose of assessment, treatment, education, and professional reasons (including social media).

Initial: ________BATHROOM CONSENT: I hearby authorize aMAYZing Kids to allow my child to use the restroom with assistance or supervision from aMAYZing Kids' staff. If my child is not toilet trained, I authorize aMAYZing Kids staff to provide a diaper change if required during my child's therapy session.

Initial: ________OBSERVATION CONSENT: I understand that aMAYZing Kids is a teaching facility and I hearby give my permission for students to participate in and observe my child's therapy with a licensed therapist present.

Form completed by: _____________________