NEW CLIENT PACKET

DEMOGRAPHIC INFORMATION Today's Date__________________

Child's Name____ □Male □Female DOB_________________

Address____
Street City/State Zip Code

Primary Insured on Insurance Policy_______________________________________ DOB________ SS#________________

Language(s) spoken in the home____

Parents/Caregivers

Mother's Name	**Father's Name**
Address	Address
Employer	Employer
Email	Email
Home Phone	Home Phone
Cell Phone	Cell Phone
Work Phone	Work phone

aMAYZing Kids has permission to contact me with medical information via email, cell or home phone and mail.

Legal Custody/Guardianship: Shared Other

Siblings: (Name/Age) ____

Other Emergency Contact and Phone Number____

Primary Concerns/Reason for Referral____

____

Onset date/change when this occurred or was noticed ____

What functional skills are limited ____

PREGNANCY & BIRTH HISTORY

Was mother's pregnancy full-term? Yes ____ No ____ # of weeks Gestation ___________

Were there any concerns/complications during pregnancy? Yes ____ No ____ Comments ________________________

____

Were there any complications with labor or delivery? Yes ____ No ____ Labor: Induced C-section Vaginal

Vacuum Suction Forceps Breech Prolonged Time Comments ____

Birth weight/length _____________ Apgar Scores ______/______ Any concerns? (seizures, jaundice, need for

oxygen, stay in NICU, congenital abnormalities, etc.) ____

Surgeries performed ____

MEDICAL INFORMATION

Primary Care Physician_______________________________________ Phone_____________ Fax_______________

Date of last physical exam____________ Date of last hearing evaluation_______ Results__________________________

Date of last vision exam ____________ Results_________________________

Does your child currently see other Specialists? (G.I., Allergy, Ophthalmologist, Neurologist, etc) please list name and contact number.

Neurologist ____

GI ____

Allergist ____

Ophthalmologist ____

Other ____

List previous therapies or services your child has received and the approximate dates he/she received them ___________

____

Is there a history of any major illnesses or hospitalizations? Yes No Comments_____________________________

____

____

Does your child have a formal diagnosis? Yes ____ No ____ Comments____

____

Are there any special medical precautions? Yes ____ No ____ Comments____

____

Number of Ear Infections___________________ How resolved? (medication, PE tubes, went away)__________________

____

Is your child currently taking any medications? (if "yes" please list medication name, dosage, and frequency) __________

____

Are immunizations up to date? Yes ____ No ____

Allergies (foods, peanuts, medications, environment, etc)

____

Is there a family history of speech delays/disorders, learning disabilities, motor delays or other developmental delays?

Yes ____ No ____ Comments ____

CURRENT CONDITION

Child's overall health (good, fair, poor) _______________ Current weight _____________ Current height ______________

Does your child sleep/nap well? Yes _____ No _____ Comments ____

____

Does/did your child ever have any problems with feeding, reflux, or breathing? Yes _____ No _____ Comments _________

____

Does your child participate in age appropriate movement activities? (rolling over, crawling, jumping, swinging, playgrounds, riding a bike, etc.) Yes _____ No _____ Comments ____

____

How is your child's current behavior? ____

____

Does your child have difficulty with separating from parents? Yes _____ No _____ Comments _________________________

____

Is your child able to calm him/herself? Yes _____ No _____ How? ____

SOCIAL/EDUCATIONAL HISTORY

Caregiver/Day Care/School____ Phone_______________Grade ________

Teacher/Daycare provider concerns? ____

____

____

How does your child interact with others? (shy, outgoing, friendly, aggressive, cooperative)___________________________

____

SELF-HELP SKILLS

	Does Independently	Needs Help
Socks/shoes		
Shirt		
Pants		
Tying Shoes		
Brushing Teeth		
Toileting		
Dresses in a timely manner		
Manipulates fasteners		
Uses a spoon		
Uses a fork		
Chews food well		
Swallows food appropriately		
Eats a variety of foods and textures		

Does your child exhibit a hand preference? R______ L ______ Does your child use scissors? Yes ______ No _______

Does your child frequently change his/her grasp on a pencil/tool? Yes ______ No ______

Does your child have difficulty sitting still? Yes ______ No ______

FEEDING & ORAL MOTOR/OT (fill out only if there are feeding concerns)

Child's current weight ________________________ Growth Chart percentile________________________________

Was your child breast fed? Yes ____ No ____ Comments ____

Was your child bottle fed? Yes ____ No ____ Comments ____

Drinks from? bottle breast sippie cup straw open cup

Utensils used fork spoon finger fed caregiver assist

History of: (please circle)

Reflux Vomiting Constipation Diarrhea Slow gastric emptying Failure to thrive

Does your child demonstrate any of the following difficulties with feeding/oral motor skills? (please circle)

Over-stuffing mouth with food Gags/vomits during feedings Frequently drools Messy eater

Strong food preferences Picky eater Avoids face washing Avoids tooth brushing

Not chewing food Spillage of food/drinks from their mouth Avoids being messy

Difficulties using cup and/or straw Mouths objects/fingers Pocketing Grazes Throws food

Food Allergies____

Special Diet ____

Shows signs of hunger YES NO

Feeding environment High Chair Table Walk Around Other_____________________

Food texture preferences (if so, please describe; crunchy, smooth, warm, cold, etc.) ______________________________

____

How long does your child sit for a meal? ____

Food likes (please list)____

____

____

Food dislikes (please list) ____

____

____

____

DEVELOPMENTAL MILESTONES

Please list what age (**in months)** that your child achieved the following skills:

Roll over _________ Sit unsupported _________ Crawl (belly) _________ (hands & knees) ________ Walk __________

Walk up/downstairs ___________ Run __________ Clap hands together __________ Wave bye-bye __________

Began saying words __________ Finger feed __________ Use spoon __________ Drink from cup __________

Dress independently __________ Use 2-3 words together _______________ Toilet Trained _______________

Do you feel your child has lost or regressed in any skills? Yes ____ No ____ If yes, what skills and when were they lost?

____

____

GROSS MOTOR/PT

History of: (please circle)

Resistance to tummy time   Not able to sit upright going down a slide   Walking on toes

Jumping one foot at a time instead of with both feet   Delayed milestones   Significant Reflux

Avoids activities where feet leave the ground   Avoids/fear of activities requiring balance

Stamps/slaps feet on ground when walking   "W" Sitting   Loses balance/trips easily or frequently

Drags feet or has poor heel-toe pattern when walking   Unable to alternate feet on stairs

Lethargic or inactive   Difficulty moving from one floor surface to another   Poor flexibility

Leans on objects/people for stability   Locks major joints for stability when applying effort

Dislikes being moved   Moves with quick bursts of activities rather than sustained effort

Joints feel loose or floppy   Seems weaker or tires more easily than peers

Concerns

____

____

____

____

SPEECH-LANGUAGE

Does your child follow directions and respond to 1 step commands? Yes ____ No ____ Comments__________________

____

How does your child communicate wants/needs/ideas (gestures, single words, sentences)? ________________________

____

Does it appear that your child can hear what you are saying? Yes ____ No ____ Comments ______________________

____

Do you have any concerns with your child's sound production (child has very few sounds, is difficult to understand, stutters, or uses his/her own language)? Yes ____ No ____ Comments____________________________________

____

Does your child respond when you call his/her name? Yes ____ No ____ Comments______________________________

____

Does your child ask for help if he/she can't do or reach something? Yes ____ No ____ Comments __________________

____

What does your child do if he/she is not understood by others?____

____

Does your child use eye contact and gestures when needing assistance or attempting to communicate frustrations?

Yes ____ No ____ Comments ____

How many words does your child have? ____

Did your child "babble" as an infant? YES _______   NO _______

Ear infections? YES _______ How many?___________   NO ________

Has your child's hearing been checked? YES_______   NO_______   If so, when? ____________________________

Can your child imitate sounds and/or words? YES_______   NO_______

Additional comments:____

____

What are your goals and expectations from assessment and/or therapy with aMAYZing Kids?________________________

____

____

I acknowledge that the information that has been reported in this document is true and correct. I understand that failure to report comprehensive information regarding my child's medical condition(s), diagnoses, and/or developmental history may compromise his/her ability to receive and participate in the appropriate and required therapy services. aMAYZing Kids reserves the right to refuse service at any time.

_________________________________   _________________________________

Parent/Guardian Name Printed   Parent/Guardian Signature and Date

Thank you for taking the time to fill this form out as completely as possible.
It makes it easier for us to help your child!

CONSENT, RELEASE, FINANCIAL RESPONSIBILITY

Child's name:____

Parent's name:____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

- I hereby authorize aMAYZing Kids to release Medical Information to my private insurance carrier as is required for determination of benefits. I also authorize payment of Medical benefits to the undersigned physician or supplier for services described below.

- I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to the party who accepts assignment below. This authorization will stay in effect until revoked by me.

If required, I allow the release of my child's medical information, as well as phone and email conversations regarding my child, to the following physicians and/or additional professionals indicated. I understand I will be informed of the content of any conversations and release of medical information that is exchanged.

Physician's Name______________________________ Additional Professional's Name_________________________

Physician's Name______________________________ Additional Professional's Name_________________________

School District______________________________ Additional Professional's Name_________________________

This authorization is valid for the duration of my child's treatment from the date signed below. I understand that I may revoke this authorization at any time, but will not hold aMAYZing Kids responsible for already releasing information in good faith. aMAYZing Kids is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

____

Signature of legal representative of child Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand that PHI can and will be used to (a) conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly, (b) obtain payment for services, and (c) conduct normal health care operations.
I understand the acknowledgement of privacy practices and understand that aMAYZing Kids has the right to change its policies and procedures, however acknowledge that AMAYZing Kids will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I understand that I may request a copy of the Notice of Privacy Practices to provide further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

____

Signature of legal representative of child Date

CONSENTS

PHOTOGRAPH RELEASE: I hereby authorize aMAYZing Kids to photograph and/or videotape my child for the purposes of assessment, treatment, education, and professional reasons (i.e. marketing materials including Facebook, flyers, website, and/or special events).

I consent to my child being photographed and/or video-taped.

I do not consent to my child being photographed and/or video-taped.

CONSENT FOR BATHROOM RELEASE: I hereby authorize aMAYZing Kids to allow my child to use the bathroom with assistance and supervision from aMAYZing Kids' staff. If my child is not toilet trained, I authorize aMAYZing Kids staff to provide diaper changing if it is required during my child's therapy visits at aMAYZing Kids Clinic. If adequate supplies for diaper changing are not available and not provided by parent, I understand that the therapy session may be suspended until adequate supplies are available.

I consent to my child having assistance with bowel and bladder care.

I do not consent to my child having assistance with bowel and bladder care.

CONSENT FOR CARE AND TREATMENT: As the child's parent or legal guardian, I hereby grant permission for the licensed therapists at aMAYZing Kids to render to my child routine therapeutic care including evaluations, therapeutic activities, educational activities, and other procedures and/or treatments prescribed by my physician and my child's therapist as is necessary in their judgment. I understand that my child is under the care and supervision of my therapist.

____

Signature of legal representative of child Date

THERAPY ATTENDANCE POLICY

We value your child's progress in therapy and consistent attendance equals better progress!

- If you must cancel an appointment, please do so by giving 24 hours' notice. We do encourage rescheduling your appointment if possible. It is essential to keep a regular schedule for any treatment to be successful. We understand that emergencies do occur. We offer the option to have your child be placed on a make-up appointment list and our one-time call-in list to try to offer as many options for therapy attendance as possible in addition to their regular appointment time.
- Cancellation Fees may be charged when applicable. Please see notice of financial responsibility for specifics.
- Two "no show" cancellations, missing more than 50% of the scheduled treatment sessions, or habitual cancellations will result in the loss of a reserved treatment time slot and/or your child being discharged from therapy.
- Scheduled vacations or extended medical absences that require a child to miss 3 or more weeks in a row of regularly scheduled appointments may result in the loss of a reserved treatment time slot and/or your child being discharged from therapy. In the event this occurs, aMAYZing Kids will attempt to prioritize resuming your child's scheduled therapy upon notice of return. However, we will not be able to guarantee the previous time slots/therapists that were being utilized prior to the extended absence.
- You will be notified as far in advance as possible when your therapist is ill, on vacation or attending a continuing education conference. Every effort will be made to reschedule your appointments so that your child will miss as little treatment as possible.

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Signature of legal representative of child Date

CLIENT NOTICE OF FINANCIAL RESPONSIBILITY- Please INITIAL EACH LINE AND SIGN AT BOTTOM

- aMAYZing Kids will file insurance claims with your insurance carrier. We are currently in-network with: Monarch, Cigna (OT/PT only), Aetna, Anthem Blue Cross, Blue Shield (Standard plans, Not Covered CA plans), TriCare, Healthnet and United Healthcare. **All parents are expected to know and understand their coverage and benefits for therapy services. We will verify elibility and if there are benefits for therapy, however it is your responsibility to know the exclusions and limits in your policy for the use of these benefits.** It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits. **A quote of benefits from your insurance company is not a guarantee of payment.** In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges. ______Initials

- Please provide aMAYZing Kids with a copy of your insurance card each time you receive a new card and/or your insurance information changes. If we do not have a copy of your card on file or you do not provide it prior to your visit so that we can verify coverage, you will be charged the self-pay rate $115 for visits until Insurance can be verified. ____Initials

- Deductibles and co-payments are due at the time services are rendered. **Any portion of the therapy fees not reimbursed by your insurance company is your responsibility**. At this time, if payment is not made on balances of 60 days or more, services will be placed on hold until the balance is paid in full. A **$10.00 statement fee** will be charged to accounts for co-pays and fees due at time of service that are not paid. ____Initials

- We will do our best to answer any insurance related questions. However, you calling your insurance company directly to verify network participation and coverage is best. Any follow-up regarding non-payment after our initial appeals process is your responsibility. **If payment is not issued by the insurance company within 60 days of our appeals filing, you are responsible for payment IN FULL for all services rendered. It is then your responsibility to follow up with the insurance company regarding any further appeals. A 10% per month interest fee will be charged on your full account balance until paid in full. _____**Initials

- Insurance companies frequently request your medical records for review. If your insurance company puts your claims on hold for review, it will delay payment for services. Due to the frequency of these requests, and the time it takes insurance to complete this process, a **$175.00 per month medical records fee** will be charged if you request to continue services that your insurance has told us will require medical review for each claim prior to processing. You can consider the option of paying the self-pay rate/fee for service or placing your child's therapy on hold until the insurance company makes a decision. Our fee **for service rate is $115 per treatment session and $402.50 for evaluations**. Any billing/statement questions may be directed to info@amayzingkids.com or 949-600-KIDS. ____Initials

- Insurance companies use procedure codes to process your claim. These codes are often referred to as units. Some insurance companies have limits on the number of units they will pay per visit. The initial evaluation and the re-evaluation will include developmental testing procedure codes that may exceed the number of units allowed through some insurance plans. It is the client's responsibility to pay for any portion of the evaluation or re-evaluation and testing that is not reimbursed by the insurance company. _____Initials

- **We may request payment for unexplained no-shows and late cancellations. We do understand that emergencies occur, and children get sick, however letting us know about it is requested to be a priority. This fee may apply to a cancellation that occurs within 3 hours prior to a scheduled time and may be billed to you at $25.00 per session. Any no show/ or calls to cancel after the scheduled appointment start time may be billed at $50.00. This will be billed on your statement and is necessary as we are unable to fill the appointment times for our therapists and accommodate all of our clients without proper notice. _____**Initials

- Any late pick up of a child after their treatment session will result in a **$2 per minute "pick up late" fee**. Please be available at the clinic at least 15 minutes prior to the end of the appointment time. ____Initials

- In the event that a check is returned for insufficient funds, there will be a fee of $35.00 due on your account in addition to the original balance. _____Initials

- Any accounts turned over to our outside collection agency or with no response for 90 days will incur an additional charge of 33% on your balance for administrative fees. ____Initials

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she has been provided the evaluation and treatment costs, is the responsible party and accepts these terms.

Signature of legal representative of child Date

Printed Name

GENERAL GUIDELINES

1. Please have your child dressed in comfortable clothing that may get dirty during therapy.

2. If your child will attend therapy for feeding, please provide food as requested by your therapist.

3. If your child will attend multiple treatment sessions, bringing a snack and diaper changing supplies is recommended.

4. If you want to observe the treatment session, please discuss this with your therapist. Due to HIPAA privacy laws, there is a specific procedure that must be followed to ensure the privacy of other clients in our therapeutic setting.

5. A portion of your child's session will be reserved to discuss your child's progress in therapy and review any home activities the therapist recommends. Please be respectful of both your therapist's time and also the next client they will see by finishing your discussion within the time allowed for the session. If you have brief additional questions to discuss regarding your child's progress, please email or call the therapist.

6. If you feel you need a significant amount of time to talk to your child's therapist, you may schedule a one-on-one appointment with your therapist. The charge for this appointment is $50.00/30 minutes. This fee is due from you at the time of the appointment and will not be billed to insurance. This appointment is also subject to our cancellation policy.

7. If you are running late for an appointment, please call the office and let your therapist know.

8. Therapy sessions range from 30-50 minutes in duration. If you choose to leave the clinic during your child's therapy appointment, please be prompt in picking up him/her when their session is over as we do not provide childcare. <u>Please return 20 minutes before the scheduled end of a session.</u>

9. Afterhours (Prior to 8 am or after 5pm) and all weekend appointments require the parent to stay at our facility for the duration of the session.

10. The therapist that performed your child's evaluation will not necessarily be the therapist that your child is scheduled with for treatment. A copy of the evaluation will be sent to you by email within approximately 4 weeks. Typically, if your child is recommended to have treatment, the treating therapist you see will be able to review the evaluation with you at your first visit if you request to do so. We are a teaching facility; therefore we will sometimes have students and volunteers involved in your child's session. At no time will your child's therapist leave a session without your knowledge.

11. Please understand that other parents may be in a treatment session near your child as they observe their child's treatment session.

Signature of legal representative of child Date