



**DEMOGRAPHIC INFORMATION**

**CLIENT ACTIVATION PACKET**

Today's Date \_\_\_\_\_

Child's Name \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_

**Insurance Information:** As a service to you, we will verify your therapy benefit information. It is **your responsibility** to provide correct information and to confirm it is correct and true at time of service.

\_\_\_\_ I am opting out of using my child's insurance for therapy services. \_\_\_\_\_ **(initial)**

\_\_\_\_ I agree to inform AK immediately of any insurance changes and I understand verification of benefits is not a guarantee of payment, claims denied by insurance will be patient responsibility. \_\_\_\_\_ **(initial)**

Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_

Provider phone # from back of card: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Diagnosis Codes: \_\_\_\_\_

Deductible: \_\_\_\_\_ Copay/Co-Insurance: \_\_\_\_\_

Visit Limit: \_\_\_\_\_ Exclusions: \_\_\_\_\_

\_\_\_\_ I have secondary insurance:

Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_

**Parents/Caregivers**

<b>Parent 1</b>	<b>Parent 2</b>
Address(if different from above)	Address (if different from above)
Employer	Employer
Email	Email
Home Phone	Home Phone
Cell Phone	Cell Phone
DOB:	DOB:

**Primary Caregiver:** Parent 1 Parent 2 Other: \_\_\_\_\_ **Marital Status:** Married Single Divorced It's Complicated

Both parents listed above have shared legal custody for medical decisions, information releases, and financial responsibility for services provided at aMAYZing Kids: (Circle One) **YES NO**

Phone: 949.600.5437

Fax: 949.600.5439

Email: [Info@amazingkids.com](mailto:Info@amazingkids.com)



Other Emergency Contact Name & Phone Number: \_\_\_\_\_

**PREGNANCY & BIRTH HISTORY**

Was mother's pregnancy full-term? Yes \_\_\_ No \_\_\_ # of weeks gestation \_\_\_\_\_ Birth weight/length \_\_\_\_\_

Were there any concerns/complications during Pregnancy? Yes \_\_\_ No \_\_\_

Comments: \_\_\_\_\_

Were there any complications with labor or delivery? Yes \_\_\_ No \_\_\_

Circle all that apply: Premature Emergency Induced/C-section Vaginal Vacuum Suction Forceps

Breech Prolonged Labor Time Cord around Neck Jaundice Need for Oxygen/breathing assistance NICU

Other/Comments: \_\_\_\_\_

Any surgeries, special equipment, consultations required during first 3 months: \_\_\_\_\_

**MEDICAL INFORMATION**

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Date of last hearing evaluation \_\_\_\_\_ Results: PASS FAIL

Date of last vision exam \_\_\_\_\_ Results: PASS FAIL

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

Neurologist: \_\_\_\_\_

GI: \_\_\_\_\_

Allergist: \_\_\_\_\_

Ophthalmologist: \_\_\_\_\_

Orthopedist: \_\_\_\_\_

Other: \_\_\_\_\_

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

\_\_\_\_\_

Is there a history of any major illnesses, surgeries 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 \_\_\_

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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: \_\_\_\_\_

Siblings: (Names/Ages): \_\_\_\_\_

**CURRENT CONDITION**

Primary concerns/reason for referral \_\_\_\_\_

Onset date/change when this occurred or age when was first noticed: \_\_\_\_\_

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/how treated: \_\_\_\_\_

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

How is your child's current behavior? GOOD FAIR POOR

Does your child have difficulty with separating from parents? Yes \_\_\_\_ No \_\_\_\_

Comments: \_\_\_\_\_

How do you help calm your child when they are upset? \_\_\_\_\_

Current school/grade and/or day care: \_\_\_\_\_

How would you describe your child's personality: (Circle One) SOCIAL EMOTIONAL INTELLECTUAL PHYSICAL

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How did you hear about us?** Friend/Family Internet/Search Engine FB YELP MD referral Health Fair Ad

\_\_\_\_\_  
Name of Person that Completed Above Information

\_\_\_\_\_  
Date



**PARENT PERMISSION and Consent for Therapy Services:** (please initial each item and sign below)

**CHILD NAME:** \_\_\_\_\_ **Parent Name:** \_\_\_\_\_

**Initial:** \_\_\_\_\_ **CONSENT FOR SERVICES/PARTICIPATION:** As this child’s parent or guardian, I give my consent and permission for my child to receive medical and wellness services by aMAYZing Kids’ therapists and staff to include evaluations, procedures and or treatments prescribed by my physician and my child’s therapist as is necessary in their judgment.

**Initial:** \_\_\_\_\_ **PHOTO CONSENT:** I hereby 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 hereby 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 hereby give my permission for students to participate in and observe my child’s therapy with a licensed therapist present.

**Initial:** \_\_\_\_\_ **LIABILITY CONSENT:** I understand that the activities in which my child and myself will engage in as part of the treatment provided by aMAYZing Kids and the physical/occupational/speech therapy activities and equipment I may use as apart of that treatment have (a) inherent risks, dangers, and hazards, and that (b) my participation in such activities and or use of such equipment may result in injury including but not limited to illness, bodily injury, disease, strains, fractures, paralysis, death or other ailments that could cause serious disability and that (c) these risks and dangers may be caused by negligence of the representatives or employees of aMAYZing Kids. By choosing to participate/have my child participate, I hereby assume all risks and all responsibility for losses or injuries whether caused in whole or in part by the negligence or the conduct of the representatives or employees of aMAYZing Kids. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future as well as on behalf of my personal representatives, my heirs voluntarily agree to release waive and hold harmless aMAYZing Kids from any and all claims, actions which may arise out of my participation and use of equipment in the activities at or recommended by aMAYZing Kids.

I acknowledge that the information that has been reported in this document and to aMAYZing Kids is true and correct. I understand that failure to report comprehensive information regarding my child’s medical condition(s), diagnoses, insurance information, 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!**

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**IMPORTANT COMPANY POLICIES**

**CHILD NAME:** \_\_\_\_\_

Thank you for choosing aMAYZing Kids. If you have any questions along the way, please do not hesitate to ask one of our staff members and we will do our best to serve you!

**Initial\_\_\_\_\_ Payments for Services.** Co-pays and/or payment towards Unmet deductibles are collected by aMAYZing Kids as your patient responsibility for services that you wish to schedule and receive. Statements will be sent if there is an additional balance due after insurance processing. Patient refunds will be provided when all services are completed or upon parent written request within 30 days. aMAYZing Kids requires patients to provide a credit card to keep on file in our secure billing software. Please be prepared to provide the front desk with a credit card to keep on file at your first appointment. If there is financial hardship, we are able to offer a Payment plan that will divide the payment into 3 payments.

**Initial\_\_\_\_\_ Cost of Care and Scheduling Availability.** aMAYZing Kids reserves the right to provide both advanced or limited scheduling for clients depending on their choice to participate in our Cost of Care estimates and Scheduling Tiers.

**Initial\_\_\_\_\_ No Shows are Bad.** It costs us money to make appointments available to you and to offer you services by our staff. Whether you attend or not we still accrue the expenses for the staff time and wages that were used to make the appointment available to you. Advance notice allows time for others who need services to reserve the appointment time as well. Please be courteous and responsible. If you No show for your Initial Evaluation, or cancel within 3 hours of an Initial evaluation appointment, you will be unable to reschedule with our office and be billed a \$50.00 no show fee.

**Initial\_\_\_\_\_ 24 Advance Notice Fee.** Please give us a 24 HOUR NOTICE if you cannot make your appointment. We do understand that emergencies occur. If you need to cancel, please call our office right away and let us know. If you must cancel with less than 24 hours notice, a late cancellation fee of \$10.00 will be charged and payable prior to your next appointment. No shows for a scheduled appointment time will be billed \$50.00. Three “no shows” and/or Late cancellations that occur within 90 days will result in the loss of a treatment time slot or possible discontinuation of services at our office. Extended absences (Vacation/Illness) that require a child to miss 3 or more weeks in a row of appointments may result in the loss of scheduled treatment time slot.

**Initial\_\_\_\_\_ Parent/Guardian/Sibling Attendance.** We appreciate and expect parent involvement during our therapy sessions. Please do not leave the premises without discussing first with your therapist and the front desk. Cell phone usage by parents during therapy sessions is discouraged as it can be distracting to your child as well as limit your ability to participate in the sessions. Other children/siblings are not able to be part of therapy sessions and cannot play on therapy equipment or with therapy toys during your child’s session. Children not in session with a therapist must be able to be supervised by a parent at all times, and recommended to bring their own toys or use waiting room toys. It is important that they do not detract from therapy sessions. Be aware you child’s therapist cannot extend the therapy session if you are late or if you are unable to supervise another child while in the session.

**Initial\_\_\_\_\_ Insurance Claims.** aMAYZing Kids will file insurance claims with your insurance carrier. All parents are expected to know and understand their coverage and benefits for therapy services. 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, charges become patient responsibility based upon the explanation of services that your Insurance carrier provides.

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**Initial \_\_\_\_\_ Insurance Denials.** If your Insurance carrier denies or delays payments for services for greater than 90 days after our office has provided the documentation for payment that we have on file, the payment for those dates of services will be transferred to patient responsibility. In addition, if your child is receiving ongoing services, we reserve the right to stop ongoing services and or the billing of your insurance for you until the payments for already provided services is resolved.

**Initial \_\_\_\_\_ Insurance Card and Prescriptions Information.** Please provide aMAYZing Kids with a copy of the front and back of your insurance card each time you receive a new card and/or your insurance information changes. We can only bill the insurance we have on file. In addition, for all PPO's, we require you to have your referring physician provide a prescription with medically based diagnosis codes for services rendered. This prescription must be updated with any changes in services, as well as with each calendar year.

**Initial \_\_\_\_\_ Assignment of Benefits.** I hereby instruct and direct my Insurance Company to pay by check made out and mailed to the address for aMAYZing Kids. OR, if my current policy prohibits direct payment to aMAYZing Kids, I hereby also instruct and direct my Insurance to make out the check to me and mail it aMAYZing Kids for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize aMAYZing Kids to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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 of legal representative



**NOTICE of PRIVACY PRACTICES HIPAA and Information RELEASE**

Child's name: \_\_\_\_\_

DOB: \_\_\_\_\_

Parent's name: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_**Initial 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.

\_\_\_\_\_**Initial** I authorize the release of any medical or other information necessary to process this claim. I also request payment of Government 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 \_\_\_\_\_

This authorization is valid from the date signed below until I revoke it. 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.

\_\_\_\_\_**Initial ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) 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 have read and 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, health care operations, and as otherwise allowed by law.

Signature of legal representative of child \_\_\_\_\_ Date \_\_\_\_\_

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