CLIENT ACTIVATION PACKET

DEMOGRAPHIC INFORMATION 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

Parent 1	**Parent 2**
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**

Other Emergency Contact Name & Phone Number:_____

Phone: 949.600.5437 Email: schedule@amayzingkids.com
Fax: 949.600.5439

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 ____

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/VIDEO CONSENT: I authorize aMAYZing Kids to photograph/ videotape my child assessment, treatment, education, and professional reasons (including social media).

Initial: _____BATHROOM CONSENT: I 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 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 a part 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 severe disability and that (c)these risks and dangers may be caused by the negligence of the representatives or employees of aMAYZing Kids. By choosing to participate/have my child participate, I 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 expressly 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 representatives, my heirs voluntarily agree to release waive and hold harmless aMAYZing Kids from any claims, actions which may arise out of my participation and use of equipment in the activities at or recommended by aMAYZing Kids staff.

Initial:_____**TELEHEALTH/PHONE Visit CONSENT**: 1. I understand that the confidentiality of medical information also applies to virtual and phone therapy and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my consent. 2. I understand that I may expect the anticipated benefits from the use of virtual therapy in my care, but that no results can be guaranteed or assured. 3. I understand that I will need to communicate with my therapist for scheduling and use the HIPAA compliant telecommunications and will be provided with synchronous video and voice communication link to conduct a therapy session that may be recorded. 4. I have read and understand the information provided above regarding teletherapy, have discussed it with my therapist or such assistants as may be designated, and my questions have been answered to my satisfaction. I give my informed consent and request the use of teletherapy to continue my child's therapy and understand this session may be recorded and the recording stored. I will be responsible for any fees not covered by my Insurance for each telehealth session.

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

Phone: 949.600.5437
Fax: 949.600.5439
Email: schedule@amayzingkids.com

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!

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_____ Illness/Stay at home policy. We will assist you with rescheduling therapy sessions to telehealth or phone session during illness. We require all participants in therapy activities and our therapists to be fever free (less than 99.9 F) for a full 24 hours, without fever-reducing medications, before attending therapy appointments. During cold and flu season/pandemic concerns, you should additionally stay home if you have symptoms such as coughing, sore throat, shortness of breath, chills, subjective fever, extra nasal congestion, extra sneezing, or flu-like symptoms. If you are informed that you have been exposed to COVID-19, we ask that you stay at home for 14 days, even if you are symptom-free. If you have tested positive for COVID-19, we ask that you stay at home until you have no symptoms and at least 10 days have passed since your first positive test.

Initial_____COVID-19/PANDEMIC Procedures for Therapy In-Person. All required paperwork should be sent through email/fax before time of service to limit front desk interactions at the clinic. In addition, payments should be provided by credit card and we will limit cash/checks. Please wait in your car until it is time for your therapy session to start, and maintain social distance from other families or visitors if you are waiting to check-in. To ensure social distancing, our waiting room will be modified for seating, and we will be designating specific treatment and sanitizing areas in the clinic. Our staff will wear face masks and gloves will be used as needed. We will not require face covering for children participating in therapy sessions, but will require a pre-screening questionnaire and non-contact temperature checks before each session. If you would like to provide individual toys, utensils, or therapy items to be used only with your child during therapy, please bring them in a labeled bag with your child, and they will be returned to you when the session is completed to take home and clean. If a parent or caregiver is required to be in the session, we will ask that visiting adults wear a face covering, remove your shoes, have your temperature checked, and participate in handwashing in the clinic as well. Please have your child/you use the restroom at home before arriving at therapy so that the building restroom is utilized for emergencies only.

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 and phone calls made if there is an additional balance due after insurance processing. Patient refunds will be provided when all services are completed and upon parent written requests 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 a financial hardship, we are able to offer a payment plan that will divide the balance due into 3 payments.

IMPORTANT COMPANY POLICIES **CHILD NAME:_____**

Initial_____ No Shows are Bad. Staffing and facility expenses are incurred when we make appointments available to you with our staff. Whether you attend or not, we still accrue the expenses for the staff time and wages for your therapy appointment time. Giving advance notice of a cancellation allows time for others who need services to reserve the appointment time instead. 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. No shows for a scheduled treatment session appt. will incur a $50.00 fee. 2 "no shows" that occur within 90 days will result in the loss of a treatment time slot and discontinuation of services at our office.

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 leave a message even if it is outside our regular office hours. If you must cancel with less than 24-hour notice, we will ask that you reschedule the appointment for another time or for telehealth. If the appointment is not rescheduled, a late cancellation fee of $20.00 will be charged and payable before your next appointment. Repeated late cancellations will result in removal from the schedule. In addition to ongoing scheduling, we do offer a call-in basis scheduling option to offer flexibility. Extended absences (Vacation/Illness) that require a child to miss 3 or more weeks in a row of appointments will be switched to our wait list or call-in basis scheduling until regular therapy attendance can resume.

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 a session with a therapist must always be supervised by a parent. Be aware your 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. Additional communication time requested to be completed with outside medical providers is best to be scheduled during your child's regular therapy appointments. If additional time is requested for communications outside of regular therapy session time, this can be coordinated by the front desk and may incur an additional fee.

Initial_____ Insurance Claims. aMAYZing Kids billing representatives 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.

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.

IMPORTANT COMPANY POLICIES **CHILD NAME:_____**

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. Changes with insurance plans must be provided to our office insurance representative prior to receiving any services.

Initial_____ Assignment of Benefits. I 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.

Initial_____ **Medical Records/Financial Records/Patient portal** Once your therapy reports and documentation are finalized by the therapist, we can send you copies of your records through a webPT Document portal that is HIPAA compliant. You will receive an email with a link to the Document portal and you must click on the link and register with the document portal within 24 hours of receiving the link. In order to register you will need to enter your email address, a secure password, and your name. Once you have registered, you will be able to access your documents by clicking on our clinic name. If you forget your password, please visit https://app.webpt.com and click forgot password and follow the prompts on the screen. If you need additional help, please try calling webPT support at 866-221-1870.
All requests for medical or financial records should be submitted by email to the front desk to schedule@amayzingkids.com. The request must state the child's name, name of requesting person, dates of service and type of service (OT/PT/SP). HIPAA release must be on file. Financial transaction history may be able to be printed, however, it will not list diagnosis codes and is limited to the detail provided in the system and cannot be customized. We require a minimum of 30 days to process if records are a current year or previous year client. If records are 2 years older or more, we will require 60 days. There is $25 fee for each case/records able to be uploaded and emailed without printing. There is a $50 fee for each case needing to be printed and faxed, scanned, or mailed.

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_____