



Rehabilitation Center

**DEMOGRAPHICS:**

Client's Name \_\_\_\_\_ Sex:  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Parent 1: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Employer: \_\_\_\_\_ WorkPhone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City/ST/zip: \_\_\_\_\_

Parent 2: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City/ST/zip: \_\_\_\_\_

Are Biological parents different than those listed above?  Yes  No

Person Completing Form: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you give the employees & independent Contractors of KidTherapy permission to contact you by e-mail regarding your child's progress, scheduling, or billing issues?  Yes  No

Client lives with:  Mother & Father  Mother  Father  Legal Guardian  Other: \_\_\_\_\_

Name & Ages of Siblings: \_\_\_\_\_

**IN CASE OF AN EMERGENCY**

Name of local friend or relative (not living at same address): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURANCE:**

PRIMARY		SECONDARY	
Company:		Company:	
Address:		Address:	
Insured name:		Insured name:	
DOB:	SS#:	DOB:	SS#:
Policy#:	Group #:	Policy#:	Group #:

Referring Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**BIRTH HISTORY:**

Issues during pregnancy? \_\_\_\_\_ Birth weight: \_\_\_\_\_  
Birth: Caesarian Vaginal Term: Full Pre-mature (# of weeks) \_\_\_\_\_

Please check all that apply to the child at or shortly after birth:

- Twin Jaundiced Breech Forceps used Cord around neck Feeding tube  
Admitted to NICU (for how long?) \_\_\_\_\_ Oxygen administered

Any other complications at birth or during the pregnancy?: \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY:**

Describe current health: \_\_\_\_\_ height: \_\_\_\_\_ weight: \_\_\_\_\_

Last Physician's Examination: \_\_\_\_\_ Next Physicians Exam: \_\_\_\_\_

Please list all surgeries, hospitalizations, and major illness since birth and dates of their occurrences:

<u>Date</u>	<u>Reason</u>

Medical Diagnosis: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_ History of Asthma? Yes No

Does your child have a history of seizures? Yes No , If so, how often does he/she experience them & when was the most recent seizure? \_\_\_\_\_

Does your child have any assistive devices? Yes No If yes, please list: \_\_\_\_\_

Formal hearing evaluation? Yes No  
If yes where? \_\_\_\_\_ Results: \_\_\_\_\_

Formal vision evaluation? Yes No  
If yes where? \_\_\_\_\_ Results: \_\_\_\_\_

Please list all Physicians and Specialists following the care of your child:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DEVELOPMENTAL:**

Student Status: full-time part-time N/A School: \_\_\_\_\_ Grade: \_\_\_\_\_

Is your child receiving school based therapy services? Yes No School diagnosis? \_\_\_\_\_

Has your child received therapy services before, and if so by whom: Yes No \_\_\_\_\_

Please describe any Developmental Concerns: \_\_\_\_\_

Describe your child's:

Sleep Habits: \_\_\_\_\_

Eat/Drink Habits: \_\_\_\_\_

Communication Skills: \_\_\_\_\_

Please note the age that your child first:

rolled over \_\_\_\_\_ sat independently \_\_\_\_\_ crawled in 4 point \_\_\_\_\_ walked \_\_\_\_\_

finger fed \_\_\_\_\_ used a spoon \_\_\_\_\_ said first word \_\_\_\_\_

Gained Bladder Control: day \_\_\_\_\_ night \_\_\_\_\_ Gained Bowel Control: day \_\_\_\_\_ night \_\_\_\_\_

Please check all that describe your child's temperaments and activities:

- |                                                      |                                                              |                                                                |
|------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> easy going                  | <input type="checkbox"/> regularly misbehaves                | <input type="checkbox"/> difficulty with transitions           |
| <input type="checkbox"/> difficult to calm           | <input type="checkbox"/> regularly fussy                     | <input type="checkbox"/> picky eater                           |
| <input type="checkbox"/> easy to calm                | <input type="checkbox"/> difficulty completing tasks         | <input type="checkbox"/> does not like to get dirty            |
| <input type="checkbox"/> easily irritable            | <input type="checkbox"/> difficulty attending to tasks       | <input type="checkbox"/> likes to be held often                |
| <input type="checkbox"/> indifferent                 | <input type="checkbox"/> difficulty leaving parents          | <input type="checkbox"/> difficulty expressing needs/wants     |
| <input type="checkbox"/> hyper focused on activities | <input type="checkbox"/> swings/ rocks him/herself regularly | <input type="checkbox"/> difficulty understanding instructions |

Does your child (check all that apply):

- stutter    drool    breathe through mouth    suck thumb (now or prior)
- have difficulty with single sounds? Which ones? \_\_\_\_\_
- complain of pain regularly?

Where is pain located? \_\_\_\_\_ Does anything relieve pain? \_\_\_\_\_

How often does he/she have pain? \_\_\_\_\_ When did pain first begin? \_\_\_\_\_

Please use this space to clarify any of the above or list any other concerns you wish to address:

\_\_\_\_\_

How does your child typically communicate his/her wants/needs? (Check all that apply)

- facial expressions    Pointing/Gestures    Taking you hand    One word    Sentences

What percentage of your child's speech would a stranger be able to understand?

- 80-100%    50%-80%    25%- 50%    0-25%

What does your child do when he/she is not understood? \_\_\_\_\_

Family History (check all that apply)

- Hearing Loss    Learning difficulties    Speech difficulties    Seizure disorder    Cleft palate
- Mental illness    Drug use    Delayed motor development (walking, crawling, etc)

If any of the above are checked, please specify relationship to child: \_\_\_\_\_

Please explain the circumstances that bring you to KidTherapy for this evaluation: \_\_\_\_\_

\_\_\_\_\_

Reason for Referral or Concerns: \_\_\_\_\_

\_\_\_\_\_

What is your goal for therapy? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

I hereby certify that I am a legal guardian for the above mentioned patient, and that the information that I have provided for KidTherapy is true to the best of my knowledge.



\_\_\_\_\_

Signature

\_\_\_\_\_

Date



Rehabilitation Center

Patients Name: \_\_\_\_\_

Kidtherapy is a provider of rehabilitation services in its free standing clinic.

### CONDITIONS OF ADMISSION TO KIDTHERAPY

**Release of Information:** The agency may disclose all or any part of the patient’s record to any person or corporation which is involved in the plan of care or may be liable under a contract to the agency or to the patient or to a family member. The agency may disclose either in writing or by oral communication any or all of the patient’s record.

**Treatment Consent:** The patient is under the control of their physician and the undersigned consents to any treatment or procedures rendered the patient by the agency under the general and specific instructions of the physician. It is further understood that the agency is authorized to carry out all instructions of the patient’s doctor and that the agency is hereby relieved of any and all liability occurring from the performance of the doctor’s instructions.

I request and authorize the staff of Kidtherapy, to provide me with the treatment and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

I authorize my insurance company to disclose information regarding my medical coverage, but not limited to verification of my insurance number, effective dates and type of coverage.

The undersigned certifies that he/she has read the forgoing and is the patient, or is duly authorized by the patient as the patient’s general agent to execute the above and accept its terms. It is further understood that this release remains in effect through the duration of therapeutic intervention unless revoked.



\_\_\_\_\_  
Signature of person authorized  
To sign in Lieu of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
KidTherapy Representative



Rehabilitation Center

RELEASE OF LIABILITY

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

I, \_\_\_\_\_ hereby release "KidTherapy" from any and all liability resulting in any possible injury caused by toys given to my son/daughter, \_\_\_\_\_, as part of their patient incentives.

⇒ \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I, \_\_\_\_\_, legal guardian of \_\_\_\_\_ understand that there are inherent risks involved with a patient's participation in therapeutic activities at KidTherapy, PLLC.

The use of equipment such as trampolines, treadmills, utensils, playscapes, climbing mats, swings, balls, and unstable surfaces among many other unlisted equipment & therapeutic toys may be used during therapeutic sessions.

Although, the staff at KidTherapy prioritizes safety with all treatment sessions, I understand that there is potential for injury while participating in activities at KidTherapy, PLLC.

I, \_\_\_\_\_ for myself, and on behalf of my heirs, assigns, personal representatives, & next of kin, hereby release and hold harmless Kidtherapy, PLLC, it's directors, officers, agents, contract workers, volunteers, employees, and other participants of, and from any and all claims, demands, lawsuits, expenses, damages, and liabilities of every kind and nature whether known or unknown with respect to any injury, disability, death, or loss or damage to person or property in connection to participation in activities affiliated with KidTherapy, PLLC to the fullest extent of the law.

⇒ \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Rehabilitation Center

Patients Name: \_\_\_\_\_

Kidtherapy is a provider of rehabilitation services in its free standing clinic.

**FINANCIAL RESPONSIBILITY**

We bill most insurance carriers for you if proper paperwork is provided to us. Since your agreement with your insurance carrier is a private one, we may not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. KidTherapy will accept cash, checks, MasterCard, and Visa. For returned checks we assess a \$25.00 NSF charge, and we may report to the local district attorney if office checks that are not paid within 2 weeks of being returned to our office.

If not paid according to terms the patient understands that our office may report to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees. The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

I hereby accept all responsibility for treatment costs not covered or reimbursed by third party payers. The undersigned certifies that he/she has been explained the treatment costs and is the responsible party and accepts these terms.



\_\_\_\_\_  
Responsible party and/or trustee  
of patient's funds

\_\_\_\_\_  
Date

\_\_\_\_\_  
Kidtherapy Representative Signature

**ASSIGNMENT OF BENEFITS**

I hereby authorize the \_\_\_\_\_, Company to pay directly to Kidtherapy, all  
Insurance Company Name  
benefits that may be due to me, if any, by reason of services described in the statements rendered, and as provided for in the above policy contract with aforementioned insurance company. I understand that Kidtherapy, which has accepted assignment, has the same right as I do to appeal carrier's determination.



\_\_\_\_\_  
Patient or Patient's agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Kidtherapy Representative Signature

**\*PLEASE SIGN ALL SECTIONS OF THIS FORM\***



## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** If you have any questions about this notice, please contact Kidtherapy's Privacy Officer at (512) 916-1511.

Kidtherapy is required by law to maintain the privacy of your health information; give you notice of our legal duties and privacy practices with respect to your health information; and follow the terms of this notice. This notice applies to all of your health records generated by Kidtherapy Rehabilitation Center, whether made by our personnel or your personal physician.

This notice will tell you about the ways in which we may use and disclose your health information at Kidtherapy and with other entities. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information as defined by federal and state laws and regulations.

### •WHO WILL FOLLOW THIS NOTICE?

Kidtherapy Rehabilitation Center; the medical staff and all practitioners granted clinical privileges at Kidtherapy

### •HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

**For Treatment**—We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), allied health practitioners, nurses, technicians, other facility or health care personnel who have a legitimate need for such information in order to take care of you. Different departments of the facility will share your health information in order to coordinate the health care services you need, such as prescriptions, lab work and X-rays. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your medical care. We may also use and disclose your health information to contact you for appointment reminders, and to provide you with information about possible treatment options or alternatives, and other health-related benefits and services. We may also disclose your health information to people outside the facility who may be involved in your health care after you leave the facility, such as other physicians involved in your care, specialty hospitals, skilled nursing care facilities and other health care-related services.

**For Payment**—We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, claims management, and medical data processing. For example, we may tell your health plan about a treatment you are planning in order to receive approval or to determine whether your plan will cover the proposed treatment. We may disclose your health information to other health care providers so they can receive payment for health care services that they provided to you, such as ambulance services. We may also give information to other third parties or individuals who are responsible for payment for your health care.

**For Health Care Operations**—We may disclose your health information for routine facility operations, such as business planning and development, quality review of services provided, internal auditing, accreditation, certification, licensing or credentialing activities, medical research and education for staff, and to other health care entities that have a relationship with you and need the information for operational purposes.

### •USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

**Subject to requirements of federal, state and local laws, we are either required or permitted to report your health information for various purposes. Some of these reporting requirements include:**

**Public Health Activities**—We may disclose your health information to public health officials for activities such as the prevention or control of communicable disease, injury or disability; to report births and deaths; to report suspected child abuse or neglect; to report reactions to medications or problems with medical products; to report exposures to environmental hazards; and to report results of lead testing.

**Disaster Relief Efforts**—We may disclose your health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition and location.

**Health Oversight Activities**—We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

**Judicial or Administrative Proceeding**—We may disclose your health information in response to a court or administrative order, a valid subpoena, discovery request, civil or criminal proceedings, or other lawful process.

**Law Enforcement**—We may release your health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar legal process;
- Regarding a victim or death of a victim of a crime in limited circumstances;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime, including crimes that may occur at our facility.

**Coroners, Medical Examiners and Funeral Directors**—We may release health information to a coroner or a medical examiner. This may be necessary, for example, to identify a person who died or determine the cause of death. We may also release health information to help a funeral director to carry out his/her duties.

**To Avert a Serious Threat to Health or Safety**—We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

**National Security**—We may disclose your health information to federal official(s) for national security activities and for the protection of the President and other Heads of State.

•Other uses and disclosures of your health information not covered by this notice or the laws that

4607 Manchaca Rd.  
Austin, TX 78745  
Office: 512-916-1511  
Fax: 512-916-1532

apply to us will be made only with your written authorization. If you provide us with authorization

to use or disclose your health information, you may revoke that authorization in writing at any time. When we receive your written revocation we will no longer use or disclose your health information for the purpose of that authorization. However, we are unable to retrieve any disclosures already made based on your prior authorization.

### •YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

#### **You have the following rights regarding your health information:**

**Right to Inspect and Copy**—You have the right to inspect your health information and obtain copies of medical, billing or other records that may be used to make decisions about your care.

The right to inspect and copy does not apply to psychotherapy notes that are maintained separately from the health record. Submit your request in writing to: Kidtherapy Medical Records Department, 4607 Manchaca Rd. Austin, TX 78745. We charge a fee for document requests to cover costs of copying, mailing or other supplies. In limited circumstances we may deny your request to inspect and copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Kidtherapy will designate a qualified individual within the center who will review your request and the denial. The person who conducts the review will not be the same person who denied your request. We will comply with the outcome of the review.

**Right to Amend**—You have the right to request an amendment to your health information that you believe is incorrect or incomplete. You must make your request in writing, using a *Request for Amendment to Protected Health Information* form, and including your reason for the amendment, to: Kidtherapy 4607 Manchaca Rd. Austin, TX 78745. To obtain a paper copy of this form, contact Kidtherapy at 512-916-1511. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- Was not created by Kidtherapy; unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Kidtherapy;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

To obtain a paper copy of this request, contact Kidtherapy at 4607 Manchaca Rd. Austin, TX 78745 512-916-1511.

**Right to an Accounting of Disclosures**—We are required to maintain a list of disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations or for treatment, payment or health care operations. You have the right to request an accounting of disclosures that were not subject to your written authorization or for treatment, payment or health care operations. Submit your request in writing to Kidtherapy 4607 Manchaca Rd. Austin, TX 78745. Your request must state a time period, not longer than six years, and may not include dates before February 01, 2006. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs

of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

**Right to Request Restrictions**—You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment or health care operations. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend. *We are not required to agree to your request.* However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You must make your request in writing to Kidtherapy 4607 Manchaca Rd. Austin, TX 78745, by submitting a request for *Restrictions to Protected Health Information* form. You must include: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply. To obtain a paper copy of this form, contact Kidtherapy 4607 Manchaca Rd. Austin, TX 78745 512-916-1511.

**Right to Request Confidential Communications**—You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at an alternative location from your home address, such as work, or only contact you by mail instead of by phone. You must make your request in writing to Kidtherapy 4607 Manchaca Rd. Austin, TX 78745, by submitting a *Confidential Communications Opt Out* form. Your request must specify how or where you wish to be contacted. We do not require a reason for the request. We will accommodate all reasonable requests. To obtain a paper copy of this form, contact Kidtherapy 4607 Manchaca Rd. Austin, TX 78745 or by phone at 512-916-1511.

**Right to a Paper Copy of This Notice**—You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a paper copy of this notice by contacting Kidtherapy 4607 Manchaca Rd. Austin, TX 78745 512-916-1511.

### •CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility. The notice will contain on the first page, in the top right-hand corner, the effective date. Upon your initial registration or admittance to the facility for treatment or health care services as an outpatient, we will offer you a copy of the current notice in effect. Whenever the notice is revised, it will be available to you upon request.

### •COMPLAINTS

You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe that we have not complied with our privacy practices. You may file a complaint with us orally or in writing by contacting Kidtherapy's privacy officer at 512-916-1511 or 4607 Manchaca Rd. Austin, TX 78745



Rehabilitation Center

**Acknowledgement of Receipt of Notice of Privacy Practices**

Your signature below indicates you have received a copy of Kidtherapy’s Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in Kidtherapy’s Notice of Privacy Practices, please do not hesitate to contact Kidtherapy's Patient Privacy Officer as indicated on your Notice.

Patient Name: \_\_\_\_\_

Patient Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

⇒ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT to PHOTOGRAPH**

I \_\_\_\_\_, parent/guardian of \_\_\_\_\_,  
(patient name)

Grant Kidtherapy permission to photograph my child during therapy sessions for use as indicated below:

Website

Marketing Materials  
(Brochures, flyers, etc)

in Clinic display

I prefer to not have any photos taken of my child.

⇒ \_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



Rehabilitation Center

Patient Therapy Contract

KIDTHERAPY REHABILITATION CENTER IS DEDICATED TO PROVIDING QUALITY REHABILITATION SERVICES TO ALL PATIENTS. A POLICY HAS BEEN IMPLEMENTED IN ORDER TO MAXIMIZE PROGRESS TOWARDS THE PROGRAM AND PATIENT'S GOALS.

AS PARENT/GUARDIAN OF PATIENT, I AGREE THAT:

1. I will give at least a 24 hour notice if unable to make a scheduled appointment. I am allowed 1 free cancellation within a 24 period. Thereafter, I will be charged a \$25 fee. If 24 hours is not possible, I will call to inform of cancellation prior to therapy session. I understand that Kidtherapy reserves the right to impose a \$50 charge for a no call/no show appointment and that this charge will be billed directly to the patient guarantor.
2. It is very important to be punctual with my appointment time. Tardiness can result in cancellation of therapy session to the respective fee.
3. I understand that after 3 no shows or 3 consecutive cancellations, my child is subject to dismissal from therapy immediately.
4. I understand my child's attendance to therapy must be consistent in order to maximize progress.
5. I understand my child cannot attend therapy services if he/she has an infection or contagious disease (example: fever, chicken pox, measles, thrush, impetigo, pink eye, strep, hepatitis, etc).
6. If there is a change in my phone number and/or address, I will inform Kidtherapy of the change immediately.
7. I understand that for the safety of my child, an adult must remain in the facility while my child is in session, or be available via phone, for immediate contact. I will advise KidTherapy of an emergency contact number if I choose to leave the premises.
8. I understand if I do choose to leave the premises during my child's session, I will return and be inside the waiting room 15 minutes before the end of the child's session or I am liable for 50 dollar late pick-up fee.
9. I understand that in case of an emergency during my child's session, I am giving permission for the employees, owners, and independent contractors of KidTherapy, PLLC to administer any first aid or CPR treatment that they deem appropriate, and call 911 for emergency medical services.



\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**