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: _____

Has your child received an evaluation from the Children's Hospital? ❑Yes, Date_____ ❑No

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: _____

Please complete next page

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:

Date	Reason

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:_____

Most recent hearing evaluation? Date_____ Results:_____

Pass newborn hearing screen? ❑Yes ❑No

Does your child have frequent ear infections? ❑Yes ❑No

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: _____

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:

❑easy going	❑regularly misbehaves	❑ difficulty with transitions
❑difficult to calm	❑ picky eater	❑swings/ rocks him/herself regularly
❑ prefers to play alone	❑does not like to get dirty	❑difficulty understanding instructions
❑ indifferent	❑difficulty expressing needs/wants	❑ hyper focused on activities
❑ irregular sleep patterns	❑ has tantrums regulardy	❑ difficulty interacting with peers
❑ difficulty separating	❑ difficulty using utensils	❑ difficulty maintaining eye contact

Does your child complain of pain regularly?

Where is pain located ? _____ Does anything relieve pain? _____

How often does he/she have pain? _____When did pain first begin? _____

Family History (check all that apply)

❑Hearing Loss ❑Learning difficulties ❑intellectual delays ❑Seizure disorder ❑Slow to talk

❑Mental illness ❑Drug use ❑Delayed motor development (walking, crawling, etc)

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

Other Family Issues of Concern (parental separation, abuse, etc.) _____

FOR SPEECH THERAPY CLIENTS:

What are your primary Concerns?

❑ Sound Production ❑ Language Comprehension ❑ Language Expression ❑ Social Skills ❑ Stuttering

❑ Feeding/Swallowing ❑ Other _____

Does your child now or have they in the past demonstrated any of these (check all that apply)

❑ stutter ❑ drool ❑ breathe through mouth ❑ suck thumb ❑ used a pacifier ❑used a bottle

❑breastfed ❑ used a feeding tube ❑ cough or choke while eating or drinking

❑ have difficulty with single sounds? Which ones? _____

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

❑facial expressions ❑Pointing/Gestures ❑Taking you hand ❑One word (about how many?____) ❑Sentences

Please check all that your child is able to do:

❑ imitate facial expressions ❑ imitate sounds/words ❑ point to objects when they are named ❑ ask questions

❑ Respond to simple questions ❑ respond to simple commands

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

What percentage of your child's speech can you understand ? _____

ALL CLIENTS:

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

_____

_____

Please explain your main concerns and reason for this evaluation: _____

_____

_____

_____

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 clinic may disclose all or any part of the patient's record to any person and/or corporation which is involved in the plan of care or may be liable under a contract to the clinic or to the patient or a family member. The clinic may disclose either in writing or by oral communication any or all of the patient's record in accordance with the Notice of Privacy Practices.

Treatment Consent: I acknowledge that the diagnosis and treatment of the patient is under the control of their physician and I consent to any treatment or procedures rendered the patient by the clinic under the general and specific instructions of the physician. It is further understood that the clinic is authorized to carry out all instructions of the patient's doctor and that the clinic 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.

I certify that I have read the forgoing and that I am legally responsible for the patient, or am 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 consent 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 clinic. 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 clinic 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

Effective 2/25/14

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

KidTherapy, PLLC is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact the privacy officer of KidTherapy, PLLC at 512.916.1511.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our KidTherapy, PLLC, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate heath professionals
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide
- Understanding what is in your record and how your health information is used helps you to:
- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other KidTherapy, PLLC personnel who are involved in taking care of you at KidTherapy, PLLC. Different departments of KidTherapy, PLLC also may share health information about you in order to coordinate your care. We may also disclose health information about you to people outside KidTherapy, PLLC who may be involved in your medical care even after you leave a KidTherapy, PLLC. This may include family members, or other healthcare professionals.
- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at KidTherapy, PLLC may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell

your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many patients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of KidTherapy, PLLC including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of KidTherapy, PLLC. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates**. There are some services provided in our KidTherapy, PLLC through contracts with business associates. Examples include medical directors, outside attorneys and an Electronic Medical Records software company . When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- **Providers**. Many services provided to you, as part of your care at KidTherapy, PLLC, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical therapist, Occupational therapist, Speech therapist), clinical labs, hospice caregivers, pharmacies, psychologists, LCSWs, and suppliers (e.g., prosthetic, orthotics).

- **Treatment Alternatives**. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services and Reminders**. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **As Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a KidTherapy, PLLC.

- **Workers' Compensation**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Reporting** Federal and state laws may require or permit KidTherapy, PLLC to disclose certain health information related to the following:

o *Public Health Risks*. We may disclose health information about you for public health purposes, including:

- Prevention or control of disease, injury or disability
- Reporting births and deaths;
- Reporting child abuse or neglect;
- Reporting reactions to medications or problems with products;
- Notifying people of recalls of products;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
- Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

o *Health Oversight Activities*. We may disclose 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.

o *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

o *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a patient has been the victim of abuse, neglect or domestic violence.

- **Law Enforcement**. We may disclose health information when requested by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at KidTherapy, PLLC; and
- 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.
- **Coroners, Medical Examiners and Funeral Directors**. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are

unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of KidTherapy, PLLC, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.

You must submit your request in writing to KidTherapy, PLLC 4607 Manchaca Rd Austin, TX 78745. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for KidTherapy, PLLC.

You must submit your request in writing to KidTherapy, PLLC 4607 Manchaca Rd Austin, TX 78745. In addition, you must provide a reason for your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for KidTherapy, PLLC; or
- Is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to KidTherapy, PLLC 4607 Manchaca Rd Austin, TX 78745. Your request must state a time period which may not be longer than six years from the date the request is submitted. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve 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 at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You must submit your request in writing to KidTherapy, PLLC 4607 Manchaca Rd Austin, TX 78745. In your request, you must tell us (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, for example, disclosures to your spouse.

- **Right to Request Alternate Communications**. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

You must submit your request in writing to KidTherapy, PLLC 4607 Manchaca Rd Austin, TX 78745. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.
- *You may obtain a copy of this Notice at our website, www.KidTherapy, PLLCaustin.com.*

To obtain a paper copy of this Notice, contact KidTherapy, PLLC *4607 Manchaca Rd Austin, TX 78745*.

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 KidTherapy, PLLC and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting KidTherapy, PLLC administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with KidTherapy, PLLC or with the Secretary of the Department of Health and Human Services. To file a complaint with KidTherapy, PLLC, contact us at 4607 Manchaca Rd Austin, TX 78745 (512)- 916-1511. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

KIDTHERAPY, PLLC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____
Address:_____
Parent Name: _____
I have been given a copy of KidTherapy, PLLC's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that KidTherapy, PLLC has the right to change this *Notice* at any time. I may obtain a current copy by contacting KidTherapy, PLLC's Privacy Official, or by visiting the KidTherapy, PLLC's web site at www.KidTherapy, PLLCaustin.com.
My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Parent, Health Care Power of Attorney)

_____

For KidTherapy, PLLC Use Only: Complete this section if you are unable to obtain a signature.
1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____
_____
2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____
Signature of KidTherapy, PLLC Representative Date

_____
Print Name

File original in patient's Business Office Record

CONSENT to PHOTOGRAPH

□ I hereby authorize KidTherapy, PLLC to take and publish photographs of _____ while at KidTherapy for the use of marketing, promotion, and recruitment purposes. Client's photograph may be used in KidTherapy publications, online, or social media, and/or displayed within the clinic or in promotional products.

I hereby release and hold harmless KidTherapy, PLLC from any reasonable expectation of privacy or confidentiality for myself and for the minor child and children listed above associated with the images taken. Further, I attest that I am the parent or legal guardian of the child or children listed below and that I have full authority to consent and authorize Kidtherapy ,PLLC to use their likenesses and names.

I further acknowledge that participation is voluntary and that neither I, the minor child, nor minor children will receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release KidTherapy, PLLC, its contractors, its employees and any third parties involved in the creation or publication of Company publications, from liability for any claims by me or any third party in connection with my participation or the participation of the minor children listed below.

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

⇨ _____ _____

Parent/Guardian Signature Date

APPOINTMENT REMINDER CONFIRMATION

Check all that apply

_____I wish to receive appointment reminders via **text message**.

My Mobile phone number is: _____

Mobile Carrier: ____Sprint ____AT&T ____Verizon ____Other(please specify)_____

_____I wish to receive appointments via email

E-mail address:_____

If you need to re-schedule or cancel an appointment, please make sure to call us at 512-916-1511. If we do not hear from you, we will assume that your appointment is confirmed. Please remember, 24 hour notice is needed an appointment.

_____ _____

Guardian's 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 any 3 missed visits without prior notice 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 mobile 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 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. KidTherapy does not assume responsibility for the payment of hospital, doctor, or EMS fees.

⇨ _____ _____

Parent/Guardian Signature **Date**