Patient Face Sheet

Patient Name: _____DOB: _____

Mother's Name: _____

Father's Name: _____

Address: _____

City: _____ Zip Code: _____

Phone #: Home: _____

Mom Cell# _____Dad Cell#_____

Mom Work# _____Dad Work#_____

E-Mail Address: _____

Would you like to be included in our Parent Connection to receive information about upcoming events, hot topics, and activities: Y or N

Emergency Contact: Name: _____

Phone# _____

Diagnosis: _____Medications:_____

Allergies: _____ Diet Restrictions_____

Sensory Aversion/Triggers:_____ History of Seizures: Y or N

Does your child receive any other services:_____

Primary Care Physician: _____Physician Phone #: _____

Insurance Company: _____

Referred By: _____

I confirm that all of the above information is accurate, and I agree to notify K.I.D.S. Therapy Associates, Inc. of any changes.

_____ **Date:** _____

Parent or Guardian Signature

Office use only ICD-9 Code(s): _____

K.I.D.S. KIDS INTEGRATING DEVELOPING SUCCEEDING
THERAPY ASSOCIATES, INC.

Please fill out completely as it is very important in order to ensure a great treatment plan.

Developmental Questionnaire

Today's Date_____

Child's Name: _____Birthdate: _____ Age: _____ Sex: ☐Male ☐ Female

Person completing this form: _____ Relationship to Child: _____

Child's Primary Care Physician: ____Referred by: _____

STATEMENT OF THE PROBLEM

Describe as completely as possible the reason for referral / concern: _____

_____

When was the problem first noticed? _____

What do you feel are some reasons for this problem? _____

Has your child received help for this problem? If so, what type? _____

Where? _____ When? _____

What would you like to accomplish through this assessment process? _____

What grade is your child in at school? _____ Who is your child's teacher? _____

☑	Has the child ever been diagnosed with:	BY WHOM	WHEN	DO YOU AGREE? Yes	No
	Autism				
	Cerebral Palsy				
	Developmental Syndrome				
	Fine Motor Problem				
	Gross Motor Problem				
	Head Injury				
	Hearing Loss				
	Learning Problem				
	Intellectual Disability				
	Neurological Problem				
	Speech and or Language Problem				
	Visual Impairment				
	Other (specify)				

Mark any evaluations or therapy received. If received by the child, mark a "C"; if received by another family member, mark an "F".

_____Speech-Language _____Occupational _____Behavioral _____Psychological

_____Physical _____Hearing _____Counseling _____Nutritional

_____Parent Training _____Educational _____Developmental

Describe results: _____

PREGNANCY AND BIRTH HISTORY

Were there any complications, illnesses, accidents, or stress-producing events during pregnancy? ☐Yes ☐No

If yes, please explain: _____

Was the baby born prematurely? ☐Yes ☐No How many weeks early? _____

Where was the baby born? _____How long was the infant in the hospital? (days/months)_____

Birth Weight: _____APGAR Scores: _____

Were there any unusual problems at birth? ☐Breathing difficulty ☐Feeding difficulties

Explain: _____

MEDICAL HISTORY

Is the child now under the care of a doctor(s)? ☐Yes ☐No Who? _____ Why? _____

Are immunizations up-to-date? ☐Yes ☐No

Is the child in pain? ☐Yes ☐No If yes, please explain: _____

Is the child taking medication? ☐Yes ☐No Type(s)? _____ Why? _____

Is the child taking herbs? ☐Yes ☐No Type(s)? _____ Why? _____

Do you think hearing is normal? ☐Yes ☐No

Has child's hearing ever been tested? ☐Yes ☐No If so, when? _____

Where? _____ Results? _____

Do you think your child's vision is normal? ☐Yes ☐No Does your child wear glasses? ☐Yes ☐No

Has child's vision ever been tested? ☐Yes ☐No If so, when? _____

Where? _____ Results? _____

Has your child experienced any of the following?

	AGE	EXPLAIN		AGE	EXPLAIN
Adenoidectomy			Eye Problems		
Allergies			Heart Problems		
Asthma			High Fevers		
Blood Disease			Meningitis		
Chronic Colds			Muscle Disorder		
Dental Problems			Nerve Disorder		
Diabetes			Seizures		
Ear Infections			Tonsillectomy		
Encephalitis			Other		

DEVELOPMENTAL HISTORY

At what age did the following occur?

Held head up:	Rolled over:	Sat alone unsupported:	Crawled:	Stand alone:	Walked alone:
Weaned from bottle:	Said first words:	Put words together:	Was toilet trained:	Followed simple directions:	

Family History

Parents' ages at birth of child: Father_____ Mother _____ Highest grade level attended: Father_____ Mother _____

Father occupation: _____ Mother occupation: _____

Please list siblings:

NAME	SEX	DATE OF BIRTH

Have any relatives (including parents, grandparents, siblings, aunts, uncles, cousins) had any of the following?

	YES	NO	IF YES, WHO?
Autism			
Developmental problem			
Drug or alcohol problems			
Hearing problems			
Hyperactivity			
Learning problems			
Mental retardation			
Psychological problems			
Seizures or epilepsy			
Severe behavior problems			
Speech problems			

Have there been any recent significant stress-producing events? ☐ Yes ☐ No For whom? ☐ Parent ☐ Child

If yes explain: _____

_____

_____

Feeding:

Check these as they applied / apply to your child:

	Yes	No	Explain (give age)
Difficulty sucking			
Difficulty chewing			
Difficulty swallowing			
Picky eater			
Prefers soft foods			
Excessive drooling			
Food comes out nose			

Language/ Communication:

What is the primary language spoken in the home: _____

What other language is the child exposed to: _____ Where: _____ How often: _____

How does your child communicate his/her needs: _____

_____

How much of the child's speech do you understand? ☐0% ☐10% ☐25% ☐ 50% ☐75% ☐100% ☐Too young to talk

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

Is your child able to follow simple direction such as come here, sit down, stop? ☐Yes ☐No

Is your child able to follow multiple step directions? ☐Yes ☐No

Does your child use words/phrases to:

Make Requests: ☐ Yes ☐ No

Comment: ☐ Yes ☐ No

Protest: ☐ Yes ☐ No

Answer questions: ☐ Yes ☐ No

Ask questions: ☐ Yes ☐ No

Play/Behavior:

Please answer yes/no about the following behaviors:

	Yes	No	Explain:
Is your child able to separate from parent/caregivers:			
Notice when you leave the room/house:			
Easy to discipline:			
Make eye contact with others:			
Play social games (peek-a-boo paddy cake):			
Show interest in other children:			
Initiate interaction with other children:			
Play with objects and/or toys appropriately:			
	Yes	**No**	**Explain:**

Play with other children appropriately:			
Imitate actions in play of other children or adults:			
Is your child able to share toys with other children or adults:			
Is your child able to take turns in activities/games:			
Know when you are upset with him/her:			

What are your child's favorite toy/ activity? _____

Does your child exhibit any of the following behaviors?

☐ Aggressiveness ☐ Lives in own world

☐ Biting ☐ Hitting

☐ Injures self ☐ Tantrums

☐ Repetitive Behaviors ☐ Rocking

Describe any other behavior that is a problem to the parents: _____

_____

How do you manage the behavior(s)? _____

_____

Sensory Processing:

Please answer the following statements:

	Almost Always	Occ.	Rarely	N/A
Does your child have irregular sleep patterns?				
Does your child seem generally weak/ floppy when held?				
Does your child seem clumsy or uncoordinated?				
Does the feel of certain clothing irritate your child?(Shirt, pants, socks, shoes)				
Does your child resist being held?				
Does your child avoid messy play activities such as finger painting, sand, glue etc.?				
Does your child seem excessively fearful of movement? (e.g. going up or down stairs, swings, slides, other playground activities)				
Does your child seek out all kinds of movements that interfere with his/her daily routines?				
Does your child startle or become distressed by loud or unexpected sounds?				
Is your child bothered by and have a difficulty concentrating with loud background noise such as construction work or machinery?				
Does your child appear not to hear certain sounds?				
Is your child sensitive to or bothered by light (squint, cries, closes eyes etc.)?				

K.I.D.S. THERAPY ASSOCIATES, INC.
KIDS INTEGRATING DEVELOPING SUCCEEDING

Patient Name: _____
DOB: _____

Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF INFORMATION

Patient's Name _____ _____
Last, First, Middle Initial Date of Birth

I, the undersigned, do hereby authorize K.I.D.S. Therapy Associates, Inc.,
San Diego, CA, to provide health information from the above-named patient's medical record to:

_____
Name and function of person or organization to which disclosure is made

_____
Address City And State Zip Code

This disclosure of health information is required for the following purpose:

_____

Dates of Service:_____ Requested information shall be limited to the following:
_____

EXPIRATION

This Authorization expires [insert date or event]:_____

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I have the following rights with respect to this Authorization:

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: K.I.D.S. Therapy Associates, Inc., 11838 Bernardo Plaza Court, Suite 110 San Diego, CA, 92128. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization. I may not be required to sign this Authorization as a condition to obtaining treatment.

APPROVAL

_____
Signature Date Witness

_____
Relationship to Patient Area Code and Phone Number Date info sent by (Name)

Patient Name: _____
DOB: _____

Conditions of Treatment

This Agreement contains the conditions of treatment of patients at K.I.D.S. Therapy Associates, Inc., San Diego, CA. The patient or the legal representative is asked to read and sign this Agreement so that the therapists treating patients at the Center may provide health care to their patients in an atmosphere where patients and their families/representatives clearly understand their rights and obligations. Please ask any questions before signing this Agreement, a legally binding contract with K.I.D.S. Therapy Associates, Inc.

1. CONSENT TO MEDICAL AID. The undersigned consents to the treatment which may be performed during visits including but not limited to, occupational therapy, physical therapy, and speech therapy.

2. TEACHING PROGRAMS. K.I.D.S. Therapy Associates, Inc. is involved in providing education and is a teaching center for training students in health professions, including but not limited to occupational, physical, and speech therapy students and other post-graduate students. The undersigned agrees that these trainees may participate in the patient's care under the supervision of the attending licensed practitioner.

3. SCIENTIFIC EDUCATION & RESEARCH. The undersigned consents to and authorizes the taking of pictures of the therapy process, for scientific, educational, or research purposes. Please note below the signature if this is not agreed to.

4. PERSONAL VALUABLES. It is recommended that valuables not be brought into the Center. K.I.D.S. Therapy Associates, Inc. is not responsible for the loss of or damage to any property or valuables brought into the Center by a patient or by a patient's visitor.

5. FINANCIAL AGREEMENT. The undersigned agrees to the payment procedure outlined. Payment for service is required at each treatment session unless another arrangement has been made i.e. payment for a month in advance. Patient will receive a billing statement to submit to their insurance company if K.I.D.S. Therapy Associates, Inc. is not a contracted provider for the patient's insurance company. It is understood by the undersigned that he/she is financially responsible for payment of services.

6. ASSIGNMENT OF HEALTH INSURANCE BENEFITS. The undersigned authorizes, direct payment to K.I.D.S. Therapy Associates, Inc. of any health benefits otherwise payable to or on behalf of the undersigned for his or her outpatient services. Should direct payment of health benefits not cover all charges, it is understood by the undersigned that he/she is financially responsible for any remaining balance.

7. LATE PAYMENT CHARGE. K.I.D.S. Therapy Associates, Inc. may assess a late payment charge of one percent per month (12.68% APR) on the unpaid balance of any account from the sixtieth day after the account becomes due and payable. In the event the account for services rendered to the patient is referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable collection costs, including and without limitation to, attorneys' fees and court costs, including costs on appeal. The undersigned agrees that if a patient payment results in a credit balance, the money may be applied to any other account which the patient or immediate family owes to K.I.D.S. Therapy Associates, Inc.

Conditions of Treatment (Continued)

8. **CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION.**

USE/DISCLOSURE OF INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS:

The undersigned understands that as part of healthcare, K.I.D.S. Therapy Associates, Inc. originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as a basis for planning for and providing care and treatment, a means of communication among the many health professionals who contribute to care, a source of information for applying the patient's diagnosis to the bill, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

USE OF PATIENT REGISTRATION INFORMATION

K.I.D.S. Therapy Associates, Inc. will use information collected in the registration process to keep the patient or the patient's legal representative informed of his/her health, research and community services opportunities, the availability of existing and new sites/settings of care/services, and notify the patient or the patient's legal representative of his/her appointments and other health related activities. Please initial on the line if the patient or patient's legal representative OBJECTS TO THE USE of registration information. _____. The undersigned certifies that he/she has read the above, received a copy, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE:_____TIME:_____

PATIENT / RELATIVE / GUARDIAN / CONSERVATOR (Circle Relationship to Patient)

Printed Name_____

Signature _____

(Rev. 1/2/15)

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for allowing K.I.D.S Therapy Associates, Inc. to assist you with your child's therapy. We understand that you have many choices in providers and we are pleased that you have selected our office.

In the interest of good health care practices, it is desirable to establish a financial policy to avoid misunderstandings. Our primary responsibility is to help our patients enjoy their therapy and get the most out of it, we wish to spend our time and energy toward that end. Our goal is to make the financial aspect as stress-free as possible.

As a courtesy to you, we will bill your insurance. **Please bring your Insurance card with you, so that we may make a copy. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim.**

Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay. We will contact your insurance company to see what therapy benefits apply to your specific plan, the information received is NEVER a guarantee of coverage, and you will have the final responsibility for understanding your insurance benefits and limitations and will be responsible for payment of services not covered by your insurance company, including but not limited to, deductible not being met, non-coverage due to the number of allowed visits being exceeded or a diagnosis not being covered. K.I.D.S. Therapy Associates, Inc. reserves the right to terminate contractual agreements with health benefits plans without express written notice to the patient.

Co-Pays are due at the time of service.

You will begin receiving monthly statements with any balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact our office. The balance of the account is due within thirty (30) days.*

CANCELLATIONS: K.I.D.S. Therapy Associates, Inc. requires 24 hours notice for cancellations; otherwise, the patient will be billed for the session. Please contact the clinic if you are not able to keep your scheduled appointment at least 24 hours in advance.

For late cancellations and no shows: You will be billed our Private Pay rates, for the duration of the missed appointment. This varies depending on therapy and appointment length. (1 hour $95, 45 minutes $71.25, 30 minutes $47.50)

I, the undersigned:

( ) have insurance coverage, and authorize direct payment from my insurance carrier to K.I.D.S. Therapy Associates, Inc.

( ) do not have insurance coverage and understand that I am responsible for payment of all charges.

I have read this financial policy and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.

PRINT PATIENT NAME:

_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

K.I.D.S. THERAPY ASSOCIATES, INC.
KIDS INTEGRATING DEVELOPING SUCCEEDING

To Parents Of Our Valued Clients:

WELCOME! K.I.D.S. Therapy Associates, Inc. considers it a privilege to have the opportunity to work with your child and assist him/her with meeting functional goals. We are honored that you have chosen our clinic, and we value the time we spend with your child.

In order to deliver quality-based services, maximize the safety of our young patients, and make sure that each child enjoys and benefits from his/her treatment session, we would like you to be aware of the following guidelines for treatment at our clinic:

- We request that you be as punctual as possible for the start and stop times of your child's session. Treatment sessions are 50 minutes for an hour session, 40 minutes for a 45 minute session and 25 minutes for a 30 minute session. The remaining time is used for parent education and documentation.
- Supervision of your child and siblings in the waiting room is expected at all times.
- For safety reasons, outside office areas cannot be used for children to run and play.
- With the exception of small infants that are held by their parent, siblings cannot accompany their brother or sister to the treatment areas (even when accompanied by a parent), unless it has been approved ahead of time by your child's therapist for therapeutic reasons only. The treatment areas are designed to provide a therapeutic environment for the patient and the therapist.
- Siblings cannot accompany their brother or sister during our group programs.
- Parents cannot use the treatment area without a therapist to warm-up your child before his/her treatment session.
- **For health reasons, therapists or other clinic staff can not change your child's diaper. Parents will be asked to change their child's diaper during the session if necessary.**
- **If you leave the clinic during your child's session, you should be able to return to the clinic within 5 minutes.**
- Therapists are happy to provide parent education during sessions. We strongly recommend that parents are informed and involved in their child's treatment process. Please do not expect therapists to have lengthy conversations with you when your child's session is over, as it is important for the therapist to have time to document and be punctual for their next client. Parent education can be provided in the following ways:
    1) Parent can accompany their child during a portion of the treatment session.
    2) Schedule an additional session for parent training.
    3) Schedule a formal phone consultation (billed in 15-minute increments).
- For confidentiality reasons:
    1) We cannot allow photography or video taping of your child if there is another patient in the treatment room. Please let your therapist know if you would like to video a treatment session, and we will schedule a treatment session during a time when no other patients are present.

2) We must be notified ahead of time if you would like a school or medical professional to observe your child during treatment. If a professional shows up without prior notice, we cannot allow him/her to enter the clinic area.
3) Additional electronic devices are not allowed in the treatment areas, i.e., cell phones, palm pilots or laptops.

- Home programs are provided for your child when necessary to assist with meeting specific goals. We ask that you try to support your child by assisting with home program follow-through in the home environment. Research suggests that practice and repetition enhances a child's ability to learn a new skill.

Once again, thank you for the opportunity to provide services to your child. Please don't hesitate to talk to us at any time if you have concerns or questions about our clinic guidelines.

Jan Dalby, Co-Director
Betsy Slavik, Co-Director

I have read and understand the above guidelines.

Parent or Guardian:_____ Date: _____

Directions to K.I.D.S. Therapy Associates, Inc.

11838 Bernardo Plaza Court, Suite 110
San Diego, CA 92128 858-673-5437

Directions: From 15 N exit Rancho Bernardo Road and turn right. At the next light, turn right onto Bernardo Center Drive. At the 2nd stoplight (the first light is for the fire station), turn right onto Bernardo Plaza Court. Shortly after you make the turn, our building is on the right hand side of the road. Turn into the second driveway at Citi Bank and drive towards the back of the parking lot. We are in Suite 110 (the second building located behind Citi Bank).

Directions: From 15 S exit Rancho Bernardo Road and turn left and go under the freeway. At the next light, turn right onto Bernardo Center Drive. At the 2nd stoplight (the first light is for the fire station), turn right onto Bernardo Plaza Court. Shortly after you make the turn, our building is on the right hand side of the road. Turn into the second driveway at Citi Bank and drive towards the back of the parking lot. We are in Suite 110 (the second building located behind Citi Bank).

K.I.D.S. THERAPY ASSOCIATES, INC.
KIDS INTEGRATING DEVELOPING SUCCEEDING

Insurance Information Form

Today's Date: _____

Patient Name: _____

Patient DOB: _____

Patient's Relationship to Insured:_____

Insured's ID Number:_____

Referring Physician:_____

Primary Insured Name:_____

Primary Insured Address:_____
(if different than patient)
Primary Insured Phone Number:_____
(if different than patient)

Primary Insured DOB:_____

Insurance Company: _____

Policy Group or FECA Number:_____

Primary Insured Employers Name:_____

Name - Insurance Plan or Program:_____

Insurance Provider Plan Phone #:_____

Another Ins. Plan/Secondary Insurance: _____
(Yes or No)

(04/2010)