Kidz Therapy Zone, LLC
32 Parkwood Drive
Chambersburg, PA 17201
(717) 446-0439 Office
(717) 312-8998 Fax
www.ktherapyzone.com

Welcome!

Welcome to Kidz Therapy Zone, LLC. Thank you for the opportunity to evaluate and treat your child and your family. It is Kidz Therapy Zone, LLC goal and mission to serve all the children in our community, coordinate therapy services in a child friendly atmosphere in order to maximize their functional independence while improving their quality of life.

An important part of insuring we can provide excellent care is knowledge, that is why we ask that you take your time and fill out these attached forms as accurately as possible. Should you need another copy of our intake forms, copies can be located on our website, www.ktherapyzone.com.

Your first appointment with Kidz Therapy Zone, LLC will take the longest due to our intake procedures. Your child's care is very important to us and we thank you in advance for your patience while working with us to provide the best care possible.

After the initial evaluation, the therapist will determine what therapy intervention is recommended. Our office will request the necessary treatment from your physician and will obtain the necessary prescription for treatment. Therapy treatment is often recommended 2-3 times per week for 30 to 60 minutes each session.

If at any time, you have questions about the process or concerns for your therapist, please do not hesitate to contact us. Please remember to bring a copy of your child's insurance card as well as completed forms to your appointment.

It is our goal to meet and exceed your expectations for therapy.

Sincerely,

The entire team at Kidz Therapy Zone, LLC

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Date: ____________________

Demographic Form

Child's Name: ______________________________ Child's DOB: ____________________

Mother Name: ______________________________ Phone: ____________________

Father Name: ______________________________ Phone: ____________________

If you are a guardian, do you have custody papers, DSS care, foster care, or power of attorney? Yes No
If yes, please provide a copy for our records.

Address: ____

City: ____________________ State: ____________ Zip Code: ____________

Who lives in the home with your child? ______________________________

Primary Contact Number: ____________________ Secondary Contact Number: ____________________

Email Address: ____

Siblings (Ages): ____

Therapy Service of Interest: SOCIAL SKILLS OCCUPATIONAL PHYSICAL SPEECH

Primary Care Physician: ______________________________ Phone: ____________________

Address: ____

Do you have a prescription from your child's Dr. for therapy? YES NO (Please provide a copy)

Primary Insurance Carrier Information:

Company: ____

Address: ____

Subscriber ID #: ____________________ Group ID #: ____________________ Other #: ____________

Pre-Auth Needed? Yes No Phone #: ____________________

Policy Holder Name: ______________________________ DOB: ____________

Policy Holder Address: ____

Secondary Insurance Carrier Information:

Company: ____

Address: ____

Subscriber ID #: ______________ Group ID #: ______________ Other #: ______________

Pre-Auth Needed? Yes No Phone #: ______________________________

Policy Holder Name: ______________________________ DOB: ______________

Policy Holder Address: ______________________________

____

Patient's Authorization for Treatment, Release of Information and Assignment of Benefits

I authorize treatment by Kidz Therapy Zone, LLC. and certify that the information I have reported is correct. I further authorize the release of any necessary information, including medical information for this or any related claims to the insurance companies, other medical personnel involved in my care, law enforcement officials, or government programs. I hereby authorize that the interests of Kidz Therapy Zone, LLC. be protected on all claims for services provided resulting from any type of accidental injury, event or occurrence. I hereby authorize Kidz Therapy Zone, LLC. to apply for benefits on my behalf for covered services rendered by Kidz Therapy Zone, LLC. I request payment from my insurance company be made directly to Kidz Therapy Zone, LLC.

I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time by giving timely written notice to the Medical Records Custodian at this office. I understand that I may not revoke this authorization for any actions taken prior to my written notice of revocation. I also understand that, if I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. If my account becomes assigned to a collection agency, I agree to pay the collection agency fee, court costs, and attorney fees. I also understand that I will pay an additional $35 for any check that does not clear the bank for any reason. I understand that I will be responsible for cancellation of any scheduled appointment 24 hours prior to that appointment; otherwise, I will be assessed a $35 non-refundable fee that will not be reimbursed by my insurance company.

Signature: ______________________________ (seal) Date: ______________

Witness: ______________________________ Date: ______________

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MEDICAL & DEVELOPMENTAL HISTORY

Were there any pregnancy complications? Yes No
Explain: ____

____

Length of pregnancy: ______________ Was prenatal care received? ______________
Mother's age at birth: ______________ Were there any delivery complications? Yes No
Explain: ____

____

The delivery was (please mark all that apply)
Induced _____ Vaginal _____ C-Section _____ Emergency C-Section _____
Number of days in hospital following delivery: _______ Birth Weight: ________ Birth Height: _________
Did your child have any complications following delivery: Yes No
Explain: ____

____

Does your child have any medical diagnoses or medical concerns: ______________

____

Does your child have any medical equipment? ______________

____

Past Medical History:
____ Allergies: ____
____ Seizures/type: ____
____ Accidents: ____
____ Operations/surgeries: ____
____ Chromosomal Disorders/Unusual Disease: ______________________________
____ Hospitalizations: ____
____ Splint/brace/wheelchair/walker/etc.: ______________________________
____ Hearing/vision Impairment: ______________________________________
____ Blood Pressure or Temp regulation difficulty: ______________________
____ Other: ____

Please list any medications, vitamins, or supplements the child is currently taking (or recently took, if pertinent): Medication Reason: ____

____

Date of most recent hearing evaluation: ______________ Did your child pass? ______________

Do you have concerns with your child's hearing? ____________________

____

Date of most recent vision evaluation: ____________ Did your child pass? ____________

Do you have concerns with your child's vision? ____________________

____

Developmental History

How does your child communicate wants and needs? Please check all that apply.

Crying _____ Pulling/leading _____ One word _____ Long sentences _____ Pointing _____

Making sounds _____ Short sentences _____ Other: ____

Please list the age that your child met the following milestones:

Supported Head	Sat Up Alone	Said First Word	Reached for Objects	Crawled	Put 2 Words Together	Rolled Over	Walked without support	Potty Trained

Please circle an answer for the following statements:

Does your child fall or lose balance easily? (YES) (NO)

Child visually looks at people/toys? (YES) (NO)

Child shows negative response when touched or touching other objects? (YES) (NO)

Child enjoys movement such as swinging or roughhousing? (YES) (NO)

Child play/participate in leisure activities daily? (YES) (NO)

Do most people understand the child? (YES) (NO)

Does the child understand instructions? (YES) (NO)

Is your child fixated with something? (YES) (NO) Explain: ____________________

Behavior/Social History

Check off all that apply to your child

Is Social and Engaging		Does Not Like New People	
Makes Good Eye Contact		Does Not Like Crowds	
Well Behaved		Has Difficulty with Transitions	
Pays Attention		Prefers to Play Alone	
Good Listener		Difficulty Paying Attention	
Plays Well with Others		Busy and Active	
Laid Back		Poor Coping Skills	
Does Well with Change		Unable to Self-Calm	
Understands Safety		Extremely Sensitive to Criticism	
Takes Turns		Aggressive	
Oppositional		Throws Tantrums	
Quickly Escalates without Apparent Cause		Outgoing	
Dislikes Touch			

What is your child's favorite activities/characters?: ______________________________

____

What calms your child?: ______________________________

____

What do you wish to gain from therapy?: ______________________________

____

Parent/Guardian Signature: ______________________________ Date: ______________

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Medical Information Release Form (HIPAA Release Form)

Name: ______________________________ Date of Birth: _____/____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Parent____

[ ] Step-Parent/Guardian ______________________________________

[ ] Doctors ____

[ ] Other____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_______________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____________________________________

The best time to reach me is (day)________________ between (time)________

Signed: _________________________________ Date: ____/____/_____

Witness:_________________________________ Date: ____/____/_____

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Release of Confidential Medical Information

Patient Name: ____

Address: ____

Phone: ______________________ DOB: ______________________

I hereby authorize the release of all the patient's confidential medical information regarding:

_________ Verbal Communication Regarding Patient Care

_________ Medical Records

_________ Treatment Notes

_________ Vital Stim or Swallowing Treatment Notes

_________ Discharge Plan & Follow up

_________ NICU Clinic

_________ Orthopedic

From: ____

TO: Kidz Therapy Zone, LLC

I understand that after the custodian of records discloses the health information, it may no longer be protected by federal privacy laws. By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effort that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____

Printed Name/Signature of Patient(or representative) Date (Expires 1 year from this Date)

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CANCELATION/NO SHOW POLICY

Kidz Therapy Zone, LLC has a 24-hour cancellation and a No-Show policy.

If you miss your appointment due to a No Show or cancel less than 24 hours prior to your appointment time, you will be charged a $35.00 fee.

If you No-Show for 3 consecutive appointments all future appointments will be forfeited. If you cancel your appointments for 6 consecutive weeks, your appointment time will be removed from our schedule. If you No Show and/or cancel in any combination for 6 consecutive weeks, your appointment time will be removed from our schedule.

This policy is in place out of respect for the therapist and our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation/No Show Policy for Kidz Therapy Zone, LLC as described above.

Thank you for your understanding and cooperation.

____

Print name

Sign: ______________________________ Date: ________________

PAYMENT FOR SERVICES AGREEMENT

Kidz Therapy Zone, LLC will provide therapy services for your child (patient) in accordance with the orders provided by the patient's physician. It is understood that licensed therapists employed by Kidz Therapy Zone, LLC will complete the services provided. The responsibly party gives permission for the patient to receive therapy services provided by Kidz Therapy Zone, LLC.

Kidz Therapy Zone, LLC will verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

The responsible party authorizes any insurance carrier that provides insurance coverage for the patient, to make direct payments to Kidz Therapy Zone, LLC for all services rendered. The responsible party will accurately inform Kidz Therapy Zone, LLC of the patient's insurance coverage and provide information regarding coverage changes within 5 working days of the change.

The responsible party authorizes the release of information pertaining to the patient's diagnosis and course of treatment to Kidz Therapy Zone, LLC by the patient's physician and any other therapy service providers involved in the patient's care. The responsibly party also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

Print Name: ______________________________________ Date: ____________________

Signature: ______________________________________ Date: ____________________

Cancelation/No Show Policy

If you No-Show for 3 consecutive appointments all future appointments will be forfeited. If you cancel your appointments for 4 consecutive weeks, your appointment time will be removed from our schedule. If you No Show and/or cancel in any combination for 4 consecutive weeks, your appointment time will be removed from our schedule. Kidz Therapy Zone, LLC will not guarantee time should you request services following removal from the schedule.

This policy is in place out of respect for the therapist and our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

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Illness Policy

To assure that illness is not spread to others Kidz Therapy Zone, LLC has adopted the below policy.

Please contact the office if your child will be absent. If a child frequently misses therapy sessions, it may be advised to contact a physician to assure of medical stability before re-scheduling services.

Please cancel your session if your child has any of the following;

- Any temperature above 100 degrees without medication, child should be temp free for 24 hours
- Vomiting or diarrhea within the last 24 hours
- Rash on the body with no known reason
- Contagious illness;
  Pink eye, Hand Foot Mouth, Strep Throat, Chicken Pox, Mumps/Measles/Rubella, RSV, Hepatitis A infection, Pertussis, Flu, COVID, etc.
- Viral/Flu like symptoms (fever, vomiting, lethargy, body aches)
- Respiratory symptoms; frequent cough/nasal drainage

If your child is on an antibiotic, please refrain from services until they have taken their antibiotic for at least 24 hours.

If your child is prescribed an Inhaler, Oxygen, and/or Epi Pen – it must be available during therapy sessions. Administration would need to be provided by the parent or caregiver.

If you have any questions or concerns about the above policy, please speak with any of our staff members. Thank you for your cooperation in advance.