Kidz Therapy Zone

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

Date: _____

Demographic Form

Child's Name: _____ Child's DOB: _____

Mother Name: _____ Cell: _____ Home: _____

Father Name: _____ Cell: _____ Home: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please take your time to thoughtfully complete this information. This information provides an overall "picture" of your child and is used by all disciplines at Kidz Therapy Zone. We ask that you complete this information **prior** to your first appointment. This will significantly reduce time by guiding the questions that need to be asked during the evaluation. It also guides the therapist regarding questions to ask or not to ask initially as they develop a relationship with your child. We also realize that there may be repetition of requested information and lengthy questions. Your tolerance is greatly appreciated. **Thank you** for helping us get to know your child so we can develop a positive relationship and comprehensive treatment program.

Person Completing this form: _____ Relationship: _____

Custodial Information ___ Not Applicable

Is there currently a **legal** custody order in place? Yes No
If **yes**, please provide a copy for our records.
Who does your child live with most of the time? _____
What is the visitation schedule w/ other parent? _____
Is there ANY legal restrictions regarding sharing of information (clinical or financial) with the child's mother / father? (a copy of the court order may be required) Yes No
Additional Information: _____
_____
Stepmother's Name: _____
Stepfather's Name: _____

Who lives in the home with your child? _____

Mother's Occupation: _____ Father's Occupation: _____

Email Address: _____

Siblings (Ages): _____

Therapy Requested: SOCIAL SKILLS OCCUPATIONAL PHYSICAL SPEECH FEEDING

Reason for Therapy: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Daycare: _____

School and Grade: _____

What kind of classroom? (reg. ed., autistic support, special ed., behavioral support, etc.) _____

Do you receive therapy services anywhere else? _____

Does your child have an IFSP/IEP/504 Plan? Yes No
If yes, please provide a copy for our records.

How did you hear about us? _____ Who referred you? _____

Primary Insurance Carrier Information:

Company: _____ Member ID: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance Carrier Information:

Company: _____ Member ID: _____

Policy Holder Name: _____ DOB: _____

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.

Print Name: _____ Date: _____

Signature: _____ (seal)

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MEDICAL HISTORY

Does your child have any medical diagnoses? _____

List other applicable doctors/specialists your child has seen or is seeing (including Developmental Pediatrician, Pediatric Neurologist, Psychiatrist, Psychologist, Ophthalmologist, etc..)

Name: _____ Specialty: _____
Address: _____

Name: _____ Specialty: _____
Address: _____

Name: _____ Specialty: _____
Address: _____

Name: _____ Specialty: _____
Address: _____

Past and Current 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: _____
____ Lead poisoning: _____
____Asthma: _____
____ Sleep Apnea: _____
____ Tonsils / adenoids removed: _____
____ Other: _____

Please list any medications, vitamins, or supplements the child is currently taking (or recently took, if pertinent). If you need more room, please attach a separate paper.

Name of Medication	Dose	Times per Day	Purpose of Medication	Prescribed By	How long on this med.

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? _____

Has your child been diagnosed with any of the following?

GE Reflux		Cardiac Issues		Esophagitis		Autism		Cleft lip	
Constipation		Neurological Issues		Developmental Delay		Genetic Abnormality		Cleft Palate	
Chromosomal Abnormality		Pulmonary Issues		Failure to Thrive		ODD		ADHD	

Family History

Does anyone in the child's family have any of the following issues?

	Yes	No	Who?
Learning Disability			
ADD or ADHD			
Mental Health			
Autism Spectrum Disorder			
Sensory Processing Disorder			
Speech Delay			
Language Delay			
Substance Abuse			
Neurological Disorder			
Neuromuscular Disorder			
Other:			

Birth History

Were there any pregnancy complications? Yes No

Explain: _____

_____

Length of pregnancy: _____ Was prenatal care received? _____

Were there any delivery complications? Yes No

Explain: _____

_____

Did your child have any complications following delivery: Yes No

Explain: _____

_____

Did your child experience any medical, developmental or feeding issues as an infant: Yes No

Explain: _____

_____

Feeding History

Does your child eat and drink by mouth? _____

Describe any difficulties with feeding that your child had as an infant (sucking, weight gain, sleeping cycle, temperament). _____

_____

How was your child fed as an infant? ___ Breast ___ Bottle ___ Tube Fed ___ Combination

How long did your child receive breast milk? _____ Formula? _____

How many different infant formulas did you use? _____

At what age did your child eat from a spoon? _____ Fork? _____

Describe any difficulties regarding your child's transition from bottle to finger foods/spoon feeding: ___

_____

How many foods does your child eat? _____

Developmental History

Hand preference: Left _____ Right _____ Switches _____

Does your child currently have difficulty with coordination skills?

Gross Motor Difficulties (Balance, jumping, running, climbing)	Yes	No
Fine Motor Difficulties (hand/finger dexterity, strength)	Yes	No
Handwriting Difficulties	Yes	No

Did your child have a very brief (or skipped) crawling stage? Yes No

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: ____

Describe your Child's current Receptive Language Skills (comprehension, Direction following): _____

_____

Describe your Child's current Expressive Language Skills (speech intelligibility, vocabulary): _____

_____

Please circle an answer for the following statements:

Did your child meet all their developmental milestone's age appropriately?	(YES)	(NO)
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 plays/participate in leisure activities daily?	(YES)	(NO)
Do most people understand the child?	(YES)	(NO)
Does the child understand instructions?	(YES)	(NO)
Can your child balance on one foot?	(YES)	(NO)
Can your child jump forward?	(YES)	(NO)
Can your child kick a ball?	(YES)	(NO)
Can your child skip?	(YES)	(NO)
Can your child walk backwards?	(YES)	(NO)
Can your child walk up and down stairs with/without holding on?	(YES)	(NO)

Is your child fixated with anything? (YES) (NO) Explain: _____

Self-Help and Adaptive skills:

Does your Child...	Frequently	Occasionally	Seldon	Never
Have difficulty falling asleep?				
Have limited food choices? (Picky eater)				
Have difficulty swallowing or chewing?				
Need help with dressing or undressing?				
Resist grooming (brushing teeth, washing hair, haircuts, nail clipping, etc.)				

Comments: _____

_____

Emotional / Behavioral History

Check off all that apply to your child:

Social and engaging		Does Not Like New People		Plays Well with Others	
Busy and Active		Does Not Like Crowds		Dislikes touch	
Well Behaved		Unable to Self-Calm		Aggressive	
Pays Attention		Prefers to Play Alone		Outgoing	
Good Listener		Plays Well with Others		Quickly Escalates without Apparent Cause	

Emotional/Behavioral Skills:	Good	Fair	Poor	Comments
Cooperation				
Motivation				
Frustration Level				
Impulsivity				
Safety Awareness				
Coping Skills				
Tolerance for Change in routine				
Self Esteem				
Separates from parent of familiar adult				
Coping Skills				
Extremely sensitive to criticism				

Tantrums: Frequency __ Never __ Seldom __ Occasionally __ Frequent
Intensity __ Mild __ Moderate __ Severe
Average # of "meltdowns" per day _____ Per week _____

Aggression: __ Verbally (loud, yell, scream, cry, say hurtful things)
__ Physically (hit, kick, bite, spit, pinch, slam doors, throw things)

Comments: _____

_____

What calms your child? _____

_____

Social Interaction:	Good	Fair	Poor	Comments
Can easily make friends				
Can maintain friendship				
Initiates conversations				
Can maintain a conversation				

Play skills:	Good	Fair	Poor	Comments
Age appropriately plays with toys				
Can play alone				
Can entertain his/herself				
Initiates play				
Will allow others to join play				
Shares				
Plays creatively				
Uses their imagination				
Participates in clean-up				
Dominates or attempts to control play				
Rough or destructive with toys				
Gets frustrated easily during play				

Preferred activities, interests, and toys: _____

_____

Fears or dislike of any toys, activities, animals, etc.: _____

_____

Additional helpful information we should know: _____

_____

_____

_____

_____

Signature: _____ (seal) Date: _____

Print Name: _____

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Medical Information Release Form (HIPAA Release Form)

Child's 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: _____

Stepparent/Guardian: _____

Doctors: _____

Specialists: _____

Daycare: _____

School: _____

Therapists: _____

Other: _____

☐ Information is not to be released to anyone.

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

Messages

Primary Contact Number: _____ Relationship to Child: _____

If unable to reach me: __ Leave a detailed message

__ Do not leave a detailed message

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ___/____/_____

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Notice of Privacy Practices (HIPPA Acknowledgment)

I hereby acknowledge that I have received a copy of Kidz Therapy Zone's Notice of Privacy Practices. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations.

Initial: _____

Release of Information & Consent for Treatment

I understand that Kidz Therapy Zone also serves as a training facility and at times other therapists and/or students may be observing, handling, treating or have supervised access to my child's medical information.

Initial: _____

I give permission for Kidz Therapy Zone to use photographs and videos taken of myself and/or my minor child during therapy sessions for educational, informational, promotion, and advertising materials.

Initial: _____

I give Kidz Therapy Zone permission to release information, verbal and written, contained in my child's medical record, and other related information, to my insurance company, physician, case manager, attorney, law enforcement officials, employer, school, related health care provider, and all other related persons to my child's treatment or payment or payment for services provided.

Initial: _____

I give permission to Kidz Therapy Zone to obtain medical records and/or professional information from my child's physician and/or another medical professional as it relates to my child's treatment.

Initial: _____

I give permission to Kidz Therapy Zone to treat my child. I permit Kidz Therapy Zone's employees and all other persons caring for my child to treat him/her in ways that they judge are beneficial to his/her care. I understand that this care can include evaluation, testing, and treatment. No guarantees have been made to me about the outcome of care.

Initial: _____

Payment Guarantee

I agree to pay Kidz Therapy Zone for services provided to my child or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for all account balances.

Initial: _____

Medical Records

I understand that there may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law and are updated annually by the Pennsylvania State Legislature.

Initial: _____

Cancellation/No Show Policy

I understand that if I No-Show for 3 consecutive appointments all future appointments will be forfeited. I understand if I cancel appointments for 6 consecutive weeks, my appointment time will be removed from the schedule. If a combination of the two occur, I understand that my appointment time will be removed from the schedule.

Please understand that this policy is out of respect for our therapists and patients.

Initial: _____

Illness Policy

I understand and will cancel my child's appointment if they have a temperature, vomiting, diarrhea, rash with an unknown cause, viral or flu like symptoms, respiratory symptoms, or any contagious illness. Contagious illness includes but are not limited to pink eye, Han Foot and Mouth, Strep throat, chicken pox, mumps/measles/rubella, RSV, COVID, Hepatitis A, Flu, etc.

I understand that my child must be symptom free and fever free for 24 hours prior to the child's return to therapy.

I understand that if the child has an inhaler, oxygen, Epi Pen, seizure medication, or suction machine it must be available during the therapy sessions. Administration would need to be provided by the parent or caregiver.

Initial: _____

Assignment of Benefits

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 to assist in helping apply for benefits for covered services. 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 the office. I understand that I may not revoke these authorizations 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 in 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 be charged and expected to pay a $35 fee for any checks that do not clear the bank for any reason.

Initial: _____

Signature: _____ (seal) Date: _____

Print Name: _____ Date: _____

Witness: _____ Date: _____