**PATIENT INFORMATION:**

|  |  |
| --- | --- |
| **Name (first,middle,last):** |  |
| **Nickname:** |  |
| **Date of Birth:** |  **Age:** |
| **Social Security Number:** |  |
| **Address:** |  |
| **Phone Number:** |  |
|  | **May we leave voice messages at this number:** [ ]  **yes** [ ]  **no**  |
|  | **May we leave text messages at this number:** [ ]  **yes** [ ]  **no** |
| **Physician:** |  |
| **Diagnosis:** |  |
| **Height:** |  |
| **Weight:** |  |
| **Emergency Contact** | **Name: Phone: Relationship:** |
| **Allergies** |  |
| **Current Medications and dosage** |  |
| **Medical Precautions** |  |
| **Dietary Restrictions** |  |
| **Is child a flight risk?** | [ ] **Yes** [ ] **No** |
| **Other restrictions:** |  |

**PARENT/GUARDIAN INFORMATION:**

|  |  |  |
| --- | --- | --- |
|  | **Parent/Guardian 1** | **Parent/Guardian2** |
| **Name:** |  |  |
| **Date of Birth:** |  |  |
| **Address:** |  |  |
|  |  |  |
| **Phone:** |  |  |
| **Email:** |  |  |

**INSURANCE: \*Please provide a copy of your child’s insurance card(s) and your ID**

|  |  |  |
| --- | --- | --- |
|  | **Primary Insurance** | **Secondary Insurance** |
| **Insurance Company:** |  |  |
| **Name of Insured:** |  |  |
| **Insured’s Date of Birth:** |  |  |
| **Insured’s Social Security Number:** |  |  |

**YOUR MAIN CONCERNS: WHY ARE YOU SEEKING THERAPY SERVICES FOR YOUR CHILD?**

**Please check all that apply.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ] **Gross Motor Skills** | [ ] **Fine Motor Skills** | [ ] **Self Care Skills** | [ ] **Sensory Regulation** | [ ] **Emotional Regulation** | [ ] **Social Skills** |
|  [ ] Balance |  [ ] Handwriting | [ ]  Dressing | [ ]  Sounds | [ ]  Hitting | [ ] Playing with friends |
|  [ ] Crawling | [ ]  Using Fork/Spoon/Knife |  [ ] Toothbrushing | [ ]  Touch | [ ]  Self Harm | [ ]  Playing with siblings |
|  [ ] Walking |  [ ] Gripping/Pinching | [ ] Hair Brushing | [ ]  Vision | [ ]  Outbursts | [ ] Cognitive/thinking |
|  [ ] Jumping | [ ] Reading | [ ]  Toileting | [ ]  Taste | [ ] Running/Bolting | [ ] Problem Solving |
|  [ ] Coordination/Clumsy |  | [ ]  Eating | [ ]  Smell | [ ] Focusing on tasks | [ ] Following Directions |
|  [ ] Frequent Falls |  | [ ]  Drinking |  | [ ] Completing tasks | [ ] Shyness |
|  [ ] Strength |  | [ ] Sleeping |  | [ ] Starting Tasks | [ ] Safety Awareness |
|  [ ] Flexibility |  | [ ] Bathing |  |  |  |
| [ ]  Bike Riding |  | [ ] Hygiene |  |  |  |
| [ ]  Joint/Muscle Pain |  |  |  |  |  |

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR CHILD’S MEDICAL AND SOCIAL HISTORY:**

**Birth History:**

|  |  |  |
| --- | --- | --- |
| **Was your child born prematurely?** | [ ]  **Yes weeks\_\_\_\_** [ ]  **No** |  **Due Date:** |
| **Type of Birth:** | [ ] **Vaginal** [ ]  **C-Section** |
| **Birth Weight:** |  |
| **Complications during pregnancy or delivery:** |  |
| **History of Post-partum depression:** | [ ]  **Yes** [ ]  **No** |

**Social History:**

|  |  |
| --- | --- |
| **Lives with:** |  |
| **Support System:** |  |
| **Community Activities:** |  |
| **Language Spoken in Home:** |  |
| **Language Spoken by Child:** |  |

**Hearing/Vision:**

|  |  |
| --- | --- |
| **Date Vision was last tested:** |  |
| **Date Hearing was last tested:** |  |
| **Concerns regarding vision/hearing:** |  |

**Surgeries/Procedures:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure/Surgery** | **Date** | **Physician/Surgeon** | **Hospital** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

**Current/Past Therapies and Medical Care:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Location/Therapist Name** | **Last evaluation date** | **Times per week** |
| **Physical Therapy (PT)** |  |  |  |
| **Occupational Therapy (OT)** |  |  |  |
| **Speech and Language (SLP)** |  |  |  |
| **Counseling** |  |  |  |
| **Habilitative Intervention (HI)** |  |  |  |
| **Ear/Nose/Throat (ENT) Specialist** |  |  |  |
| **Neurologist** |  |  |  |
| **Other:** |  |  |  |

**Please indicate current or past medical needs in the following areas:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Comments** |
| **Heart** |  |  |  |
| **Breathing** |  |  |  |
| **Digestion/Elimination** |  |  |  |
| **Circulation** |  |  |  |
| **Seizures** |  |  |  |
| **Other:** |  |  |  |

**I have reviewed this information packet. All of the above is true and current to the best of my knowledge.**

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_**

***RELEASE OF INFORMATION***

Please list the providers that you see (physicians, service coordinators, therapists, caseworkers, specialists, counselors, consultants, teachers, schools, etc.) so that we may collaborate with them.

|  |  |  |
| --- | --- | --- |
| **Name** | **Address** | **Phone** |
| Primary Care Physician: |  |  |
| School:Teacher:IEP/504: [ ]  Yes [ ]  No |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***MEDICAL RELEASE OF INFORMATION***

I give my permission for the exchange of written/electronic/oral communication between the above listed care providers/doctors/insurance companies, and Kids in Motion Physical Therapy, PC (DBA: All About Kids Pediatric Therapy). I understand that my records may be reviewed by state representatives for the purpose of insurance certification, or by therapists or doctors for the purpose of collaboration of care, professional peer review, licensing or quality assurance. I understand that all practices of confidentiality, following HIPAA compliance standards, will be followed in use of the information gathered. I may revoke or limit this permission at any time.

***PLEASE request RECORDS from all EDUCATIONAL and MEDICAL RESOURCES be FAXED to***

***(208) 561-9705. This is a confidential fax line.***

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ASSIGNMENT OF BENEFITS AND RELEASE:**

I, the undersigned, authorize therapy for my child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and certify that my dependent has insurance coverage(s) as listed above. I assign directly to Kids in Motion Physical Therapy (DBA: All About Kids Pediatric Therapy) and their agents, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, to submit billing to, and assign benefits for therapy services to my above listed insurance(s) for reimbursements.

**Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTENDANCE POLICY**

Consistent attendance is a vital component of your child’s success in therapy. We understand that there are instances when missing therapy is necessary (i.e. illness, family emergency, family vacation).

**Twenty-four hour notice of absences is requested.**  If you are unable to attend your appointment, please call as soon as possible.

In order for your child to make progress, all missed appointments should be made up.

We strive to schedule your appointment at the time that is best for you to assure your attendance. **If three appointments are missed without prior notification from you, you will be placed on a wait list until we can reschedule your appointments to a time that will guarantee your attendance.**

We reserve the right to charge a $25 no show fee for appointments missed without 24 hour notice of cancellation. This fee will be billed to the parents/legal guardians.

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_**

**OFFICE PAYMENT POLICIES:**

We believe the best business arrangement is based on mutual understanding between you and our office. To ensure this understanding, our office policies are listed below. Your signature is acknowledgement that you have read, and will abide by the policies stated. Payment for services will be required at the time of service unless arrangements are mutually agreed upon. We accept cash, check, credit/debit cards, and money orders. All insurance recipients will be responsible for what is not covered by their insurance.

1. Our office will file claims on a weekly basis for patients who wish to use their insurance benefits. This office will fill out the necessary forms; the client is responsible for payment within 60 days of service. We must emphasize that our relationship is with you and not with your insurance company, and we are not a party to that contract. Please keep us informed of “length of care” clauses in your policy.
2. Patient families/guardians are responsible for understanding the limits to their insurance coverage and how this effects their financial responsibility (deductibles, co-pays, co-insurance).
3. Patient statements will be sent monthly.
4. Periodic progress notes will be sent to your referral source and/or physician for the purpose of providing continuity of care. There is no charge for this service. Others that should receive therapy information must be listed on our Release of Information list.
5. School conferences and scheduled consultations may be charged a fee based on the length of the conference, travel time and mileage. Insurance companies may not assume these costs.

All About Kids is a subsidiary of Kids in Motion Physical Therapy. Billing is conducted under the name of Kids in Motion Physical Therapy; therefore, this name may appear on insurance and billing statements.

**Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDER NOTICE OF PRIVACY PRACTICES:**

I acknowledge receipt of a copy of Kids in Motion Physical Therapy (DBA: All About Kids Pediatric Therapy) Privacy Practices. I understand I can review the All About Kids Notice of Privacy Practices at any time, as it is publicly displayed and available for review in the entryway to the treatment area at All About Kids. It is also available on our website: sandpointkidstherapy.com

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**TREATMENT SITE:**

I give permission for my child to be treated at the following (please initial):

\_\_\_ 1. The patient’s home

\_\_\_ 2. All About Kids: 110 Tibbetts Dr, Ponderay, ID 83852

\_\_\_ 3. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_I give permission for the patient to receive therapy without parent/guardian present

\_\_\_\_I authorize the treating therapist to seek emergency medical attention for the patient if deemed necessary **Emergency Contact Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THERAPY DOG RELEASE**

All About Kids Pediatric Therapy is pleased to have Aspen, a certified therapy dog, owned by one of our therapists, Dani Meehan, MOT, OTR/L, as a team member. Aspen, a female black golden doodle therapy dog, is in our clinic as an additional, proven therapy intervention.

Please read the following statements. We believe that you know your child best, and we support your decision regarding your child’s interaction with Aspen. You can change your choice regarding interaction with Aspen at any time.

We welcome recommendations and thoughts you may have about our therapy dog intervention teammate. All About Kids Pediatric Therapy endeavors to create as safe an environment as possible, including safety with Aspen. We also recognize that both animal behavior and kids’ behaviors can be unpredictable. We recognize that not every child or adult may want to interact with Aspen.

If acceptable to you, please initial your decision below and sign

\_\_\_\_\_\_Aspen, a trained therapy dog, may be present with, and interact with, my child under the direct supervision of a licensed therapist. I understand animal behavior and kids’ behavior is unpredictable. I agree to waive and hold harmless All About Kids Pediatric Therapy from any liability regarding injury, damages, expenses that might be involved in interaction with Aspen, a therapy dog.

\_\_\_\_\_\_I am not comfortable having Aspen, a trained therapy dog, interact with my child, but Aspen may be in the same room as my child.

\_\_\_\_\_\_I do not consent for Aspen, a trained therapy dog, to be in the same room with, or interact with my child in any way.

This agreement will be effective until your child is discharged from therapy at our clinic.

You may change or revoke your decision at any time.

Parent/Guardian’s name(printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STUDENT THERAPIST AND OBSERVER CONSENT**

All About Kids is a teaching facility. We accept master and doctorate level trained therapy students during their final months of clinical internships. At our facility, masters and doctorate level trained therapy students have the opportunity to learn and practice pediatric evaluation and treatment techniques. A licensed therapist supervises the student, offering input and assistance as necessary. We also accept individuals who are interested in attending therapy school to observe our sessions in order for them to determine if pediatric therapy is a field they would like to pursue; these observers do not participate in therapy sessions.

We accept master and doctorate level trained therapy students for internships because:

* There is a shortage of pediatric therapists in the United States. It is our professional responsibility to promote the training of well qualified pediatric therapists to fill this need.
* Master and doctorate level trained therapy students are trained in current best practice evaluation and treatment, current on the most recent research. We can learn new techniques with our students that will benefit our patients.
* Having a masters or doctorate level trained student challenges us to keep up with current best practice evaluation, treatment and teaching methods.

It is your decision, as a parent, to determine whether a masters and doctorate level trained therapy student will work with your child, or an individual may observe your child’s session. Please initial next to the appropriate statement below, indicating your preferences regarding a student working with your child. We fully support and respect your decision.

\_\_\_\_\_\_Master and doctorate level trained therapy students may evaluate and treat my child under the direct supervision of a licensed therapist.

\_\_\_\_\_\_I am not comfortable having masters or doctorate level trained therapy students evaluate or treat my child but students may observe the evaluation/treatment/collaboration sessions.

\_\_\_\_\_\_I do not consent for a master and doctorate level trained therapy student to be part of my child’s pediatric therapy evaluation/treatment/collaboration in any way.

\_\_\_\_\_\_My child’s session may be observed by an individual wishing to pursue therapy as a career.

This agreement will be effective until your child is discharged from therapy at our clinic. You may change or revoke your decision at any time.

**Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_**

**Photography/Video Release**

Photographs and videos can be very useful tools to evaluate and monitor progress of patients. We also use photographs and videos to share information about our clinic to health care facilities and the public. We respect your privacy and will only take photographs/videos with your consent. Please initial the statements that you consent to and sign at the bottom of this page. Consent may be revoked at any time.

\_\_\_\_\_\_\_ I consent to photographs/videos being taken of my child for the purpose of evaluation and progress monitoring.

\_\_\_\_\_\_\_ I consent to photographs/videos being taken of my child and shared on social media platforms for All About Kids Pediatric Therapy.

\_\_\_\_\_\_\_ I consent to photographs/videos being taken of my child and shared on the All About Kids Pediatric Therapy Website (sandpointkidstherapy.com).

\_\_\_\_\_\_\_ I consent to photographs being taken of my child and shared on marketing materials (i.e. brochures) for All About Kids Pediatric Therapy

You may change or revoke your consent at any time.

Child’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_**