Child Name: _____**Child DOB**: _____
Address:_____

Diagnosis (if known):_____

PrimaryPediatrician/Physician: _____

Group name:_____ **Physician's Phone:** _____

Address: _____

Other doctors and specialists who provide care to this child:

Name	Specialty	Phone Number

Family Background

Name of Mother/Guardian_____

DOB:_____ Social Security#: _____

Mother's Cell Phone_____ Home Phone_____

Home Address_____

City_____ State_____ Zip Code_____

Employer_____ Work Phone_____

Email Address_____

Patient Name: _____

Name of Father/Guardian_____

DOB:_____ Social Security#: _____

Father's Cell Phone_____Home Phone_____

Home Address_____

City_____ State_____ Zip Code_____

Employer_____ Work Phone_____

Email Address_____

Brother(s) and/or Sister(s) of the child:

Name	Age

Describe in your own words the nature of your concerns about your child's development:

_____

_____

_____

Is your child currently receiving therapy services? Yes No

If "Yes", what services: {_____OT}{ _____PT}{ _____SLP}{ _____Other}

Location and Frequency_____(how many times per ___week or ___month)

Last Evaluation Date: Services: {_____OT}{_____PT}{_____SLP}{_____Other}

– –

Has your child ever received therapy? Services:{_____OT}{ _____PT}{ ____SLP}{ _____Other }

Location and Frequency_____(how many times per ___week or ___month)

Last Evaluation Date:_____, Services: {____OT}{____PT}{____SLP}{_____Other}

Patient Name: _____

Medical History

Was your child born prematurely? Yes No

If yes, at how many weeks was your child born? _____

Were there any complications during the pregnancy? Yes No

If yes, please describe:

_____

How long did your child remain hospitalized after he/she was born? _____

What was your child's birth weight? _____

Please list any hospitalizations and/or medical procedures your child has received:

_____

_____

_____

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies: Yes No If yes, please describe:

_____

_____

Does your child have a history of recurrent ear infections? Yes No If yes, has he/she had PE tubes placed to treat the condition? Yes No

Date last PE tubes were inserted: _____

Patient Name: _____

Education Information

Is your child currently enrolled in school? Yes No
If "Yes", where and days attended:_____

Does your child receive any services through the school? Yes No
If "Yes", what services? _____

Does your child have a current Individualized Education Plan (IEP)? Yes No

Developmental History

Please indicate at what age your child achieved the following milestones:

*Mark N/A for those which your child has not achieved yet

Rolled over_____ Babbled_____

Sat alone_____ Said first word_____

Crawled_____ Drank from a cup_____

Pulled to stand_____ Used spoon_____

Stood alone_____ Toilet trained_____

Walked alone_____ Dressed self_____

Current physical limitations:_____

Comments:_____
_____
_____

Patient Name: _____

Social/Emotional History

What are your child's favorite toys/activities?

_____
_____
_____

What typically calms/soothes your child? _____
_____
_____

Does your child become easily frustrated with activities? If yes, please describe his/her behavior._____
_____
_____

Does your child interact with other children, or primarily play alone?

_____
_____
_____

Is your child currently enrolled in any community activities (such as music class, play groups, Mother's Morning Out Program)? If so, how would you describe your child's behavior compared to other children involved in the activities?

_____
_____
_____
_____

_____ _____ _____

Printed name of person completing this form Relationship to child Date

Patient Name: _____

PRIMARY INSURANCE:

Name of Insured_____

Birthdate_____ Social Security #: _____

Relationship to Patient_____

Insurance Company Name_____

Claims Address_____

City_____State_____Zip Code_____

Customer Service Telephone_____

Group Name_____ Policy Number_____

Group Number _____

ADDITIONAL INSURANCE:

Name of Insured_____

Birthdate_____ Social Security #: _____

Relationship to Patient_____

Insurance Company Name_____

Claims Address_____

City_____State_____Zip Code_____

Customer Service Telephone_____

Group Name_____ Policy Number_____

Group Number _____

Clinic Address: _____

Clinic Telephone Number: 770-207-6390 Clinic Fax Number: 678-374-4855

Patient Name: _____

DOB: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:

I hereby request that payment of authorized health insurance plan and/or Medicaid benefits be made on my behalf to Activekidz of therapy services provided. I authorize Activekidz to release and/or receive information from/to my third party payer/insurer and/or to the Health Care Financing Administration and it's agents, if necessary, any medical needed to determine the benefits payable for related services. I understand I will be personally responsible for any amount denied, or any remaining amount owed for services partially covered by my third party payer/insurer. I also authorize Activekidz to release and/or receive information from/to schools, doctors including specialist/surgeons and DFCS

I authorize the following individuals to have access to my child's records:

_____

_____

Patient/Guardian_____ Date_____

FINANCIAL POLICY

Please initial beside each paragraph stating your understanding of each item

_____ If you have a deductible, we will ask that you make a down payment of $100 for an evaluation and $50 at each therapy appointment. As soon as we begin receiving claims back, we can give you a definite price for each visit and we ask that this be paid at the time of service.

_____ We verify your benefits with your insurance company prior to your first appointment with us. However, the benefits quoted to us are not a guarantee. Your insurance may pay differently than what is quoted. It is ultimately your responsibility to know how your insurance will cover you for your services with us.

_____ We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment or your estimated share be made upon receipt of your billing. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

_____ In the event that you run out of approved visits through your insurance company, you will be considered private pay until the next calendar year begins with your insurance company. In order to receive the private pay rate, you will be asked to pay at each visit.

_____ If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to us by forwarding the actual payment with explanation of benefits to our office, with endorsement made and reassigned to provider.

_____ I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

_____ Medical Records will not be released to any person or other medical facility if there is an unpaid balance on the account.

I have read the above information and understand my responsibility for the payment of my account.

Patient/Guardian_____ Date_____

ATTENDANCE POLICY

Activekidz is pleased that you have chosen us to provide your child with their therapy needs. We provide services to many children in the surrounding areas and unfortunately have to turn children away due to our therapist's full schedules. Your child must be present for at least 75% of scheduled therapy sessions or services may be terminated. We request that you cancel your child's appointment with *all therapists* that you are seeing 24 hours prior in order for us to see another child in need. We do understand that emergencies arise and we are more than willing to work with each case as it arises. If you cancel the day of your scheduled appointment you will be charged a $15 fee per child. If you are not present for a scheduled appointment, you will be charged $25 fee per child. If your child's appointment can be rescheduled during the same week you will not be responsible for payment of any fees. If you have 3 no shows without prior notification then services will be terminated. All fees will be collected at the next scheduled appointment. We greatly appreciate your understanding in this matter.

Patient/Guardian_____ Date_____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Activekidz, Inc., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Activekidz, Inc.
I understand that diagnosis or treatment of me by Activekidz, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice.

Babies Can't Wait is a statewide early intervention program for children (birth to 3 years of age) with developmental delay. Babies Can't Wait can assist families in identifying needed resources and services within our community to meet a child's developmental needs.

Activekidz, Inc. is not required to agree to the restrictions that I may request. However, if Activekidz, Inc. agrees to a restriction that I request, the restriction is binding on Activekidz, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that Activekidz, Inc. or Activekidz, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Activekidz, Inc.'s Notice of Privacy Practices prior to signing this document.

The Activekidz, Inc.'s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Activekidz, Inc.

The Notice of Privacy Practices for Activekidz, Inc is also provided in the Office Manager's office and will be on the Activekidz, Inc. website when developed.

The Notice of Privacy Practices also describes my rights and the duties of Activekidz, Inc. with respect to my protected health information.

Activekidz, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
I may obtain a revised notice of privacy practices by accessing the Activekidz, Inc.'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient/Guardian_____Date_____

NOTICE: PATIENT PRIVACY

Date January 1, 2011

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

ACKNOWLEDGEMENT:

I acknowledge by signing below that I have received and read or had explained to me this Notice of Privacy Practices for Activekidz, Inc.

Child's Name:_____

Parent/Legal Guardian:_____Date:_____

Activekidz & Adult Therapy

Tel: 770-207-6390 Fax: 678-374-4855

Photo Release Form for Minors

Activekidz and Adult Therapy has my permission to use my child's photograph publicly to promote their organization. I understand that the images may be used in print publications, online publications, presentations, websites and social media. I also understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

_____ _____

Parent/Guardian's Signature Date

_____

Parent/Guardian's Name

_____

Child's Name

_____ I do not authorize any photos to be taken of my child.