ALL ABOUT KIDS PEDIATRIC THERAPY
1218 N Division, Suite 102 Phone: 208-255-7337 Fax: 208-561-9705

PLEASE PRINT ALL INFORMATION WITH BLACK OR BLUE PEN

Child's First, Middle, Last Name________________________________ Nickname: _______________ **Date**______________

Date of Birth: _________________________ Age: _____________Social Security Number: _____________________

Physician: ______________________________

Diagnosis, if any: _______________________________________Date of Onset: _____________________

Address: ____City: _________________ zip: ______

Best Phone to contact you: ________________

EMERGENCY CONTACT Name: ______________________ phone: ___________

Who may we thank for this referral? ____

Parent/Guardian Information if under 21 years old:

Name: ____________________________	Name: ____________________________
Date of Birth: _____________	Date of Birth: _____________
Relationship to you: _____________________	Relationship to you: __________________
Contact Info: ☐ same as above	Contact Info: ☐ same as above
Address: _______________________________	Address: __________________________
Phone(s): ________________________________	Phone(s): ________________________
Email: __________________________________	Email: _______________________________

Insurance Information: **Please give us a copy of your child's insurance card and your driver's license**

Healthy Connections Physician, if applicable: ____

Primary Insurance: ____

Address: _________________________ City: ___________________ zip: _____ Phone: _____________________________

Name of Insured: ____________________________________ Date of Birth: ___________

Social Security Number: _______________________________

ID#: __________________________________ Group #: _______________________

Secondary Insurance: ____

Address: ____________________ City: ____________ zip: ______ Phone: _____________________

Name of Insured: ___________________________________Date of Birth: _____________

Social Security Number: ____________________________

ID#: __________________________________ Group #: _______________________

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Your Child's First Initial, Last Name_________________________________

YOUR CHILD'S MEDICAL AND SOCIAL HISTORY:

Birth History:

Was your child born prematurely? □ Yes, Due Date_______________ □ no

□ Vaginal Birth □ C-section Birth Weight: _____________

Complications during pregnancy/delivery: ______________________________________

History of maternal post-partum depression? □ yes □ no

Most current Vision/Hearing:

Vision Tested? □ Yes, Date__________________ □ No

Hearing Tested? □ Yes, Date_________________ □ No

Concerns regarding vision/hearing: _____________________________

Height: ______________________ Weight: ______________________

Medications (prescription, over the counter, supplements, name, dose, frequency):

____

Surgeries/Procedures: (use back of paper if needed)

Date: ____________________ Procedure/Surgery: __________________________________

Physician/Surgeon: _________________________Hospital: ___________________________

Date: ____________________ Procedure/Surgery: __________________________________

Physician/Surgeon: _________________________Hospital: ___________________________

Date: ____________________ Procedure/Surgery: __________________________________

Physician: _________________________________Hospital: ___________________________

CURRENT OR PAST THERAPIES:

	Location	Last evaluation date	Times per week
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Counseling			
Counseling, extra assignments, other supports			

Please indicate current or past needs in the following areas:

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	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking			
Allergies			
Eating			
Drinking			
Seizures			
Other:			

FAMILY HEALTH HISTORY

Does your **family** have a history of any problems/difficulties in the following areas?

	Y	N	Comments
Vision			
Hearing			
Communication			
Heart			
Breathing			
Circulation			
Emotional/Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking			
Allergies			
Seizures			

Please describe where you live, your support systems, friendships

____

____

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What do you see as your child's needs, areas where you could use support?

____

____

What are your child's strengths? ____

____

____

Please summarize your goals for your child. What would you like to accomplish in therapy?

____

____

____

Fine motor goals

____

____

Gross motor goals

____

____

Social goals, self-care goals

____

____

____

____

Other goals

____

____

____

I have reviewed my information packet All of the above is, to the best of my knowledge, true and correct.

Parent/Guardian's Signature ______________________________ **Date** __________

Please initial here when completing original paperwork: date: ____/initial____

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Your Child's First Initial, Last Name_________________________________

RELEASE OF INFORMATION

Please list the providers that you see (physicians, service coordinators, therapists, caseworkers, specialists, consultants, teachers, schools, etc.) so that we may collaborate with them. We will obtain your verbal permission prior to contacting any of the entities listed below:

Primary Care Physician: ____________________________phone: ______________
Address: ____
Most recent visit: ______________________

School: ____
Teacher: ____
____
I have had or currently has an: ☐ IEP ☐504 Plan

Name ____ phone _____________
Address____
Most recent visit_________________________

Name____ phone _____________
Address____
Most recent visit_________________________

Name ____phone _____________
Address____
Most recent visit_________________________

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 PT, 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.

ASSIGNMENT AND RELEASE:

I, the undersigned, authorize therapy for me___________________________, and certify that my dependent has insurance coverage(s) as listed above. I assign directly to Kids in Motion PT, All About Kids OT. 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 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/Guardian's Signature:_________________________________Date:

PLEASE request RECORDS from all EDUCATIONAL and MEDICAL RESOURCES be FAXED to (208)561-9705. This is a confidential fax line.

OFFICE PAYMENT POLICIES:

Please initial here when completing original paperwork: date: ____/initial____

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Your Child's First Initial, Last Name________________________________

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, and money orders. All insurance recipients will be responsible for what is not covered by their insurance.

1. Our office will file claims at the end of the month and/or at the end of each session 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. Interest at 1.5 (18% per year) will be added to any balance more than 60 days past due. Clerical fees will be a monthly flat fee of $5.00 for unpaid balances being carried forward. Please keep us informed of "length of care" clauses in your policy.
2. 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 disclosure list.
3. School conferences and scheduled consultations will be charged a fee based on the length of the conference, travel time and mileage. Insurance companies may not assume these costs.

Please Note: Twenty-four-hour notice of absences is requested. If you are unable to attend your appointment, **please call.** 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, will be placed on a wait list until we can reschedule your appointment to a time that will guarantee your attendance.** We reserve the right to charge a $25 no show fee for appointments missed without notice of cancellation. This fee will be billed to the parents/legal guardians. Insurance companies, Medicaid and Tricare do not reimburse for missed appointments; this will be the sole responsibility of you and your parent/legal guardian.

Parent/Guardian's Signature:__________________________________Date:

PROVIDER NOTICE OF PRIVACY PRACTICES:
I acknowledge receipt of a copy of All About Kids 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.

Parent/Guardian's Signature:__________________________________Date:

TREATMENT SITE: I give permission for my child to be treated at the following:

___ 1. The patient's home

___ 2. All About Kids: 1218 N Division, Ste. 102

___ 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's Signature:__________________________________Date:

Please initial here when completing original paperwork: date: ____/initial____

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Your Child's First Initial, Last Name_________________________________

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:______

Please initial here when completing original paperwork: date: ____/initial____

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All About Kids is a teaching facility. We accept masters 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 attends and supervise the student, offering input and assistance as necessary.
We accept masters 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.
-Masters 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. 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.

______Masters 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 masters and doctorate level trained therapy student to be part of my child's pediatric therapy evaluation/treatment/collaboration 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 Signature: _______________________________Date:______

Please initial here when completing original paperwork: date: ____/initial____