New Client Demographic and Medical History Consent Form

Child's Name:		DOB:		
Address:		Gender:	M	F
City, State, Zip Code:				

Parent/Guardian:		
Relationship to Child:		
Mailing Address:		
Email Address:		
Best Contact Numbers:	Cell#:	Home#:

Parent/Guardian:		
Relationship to Child:		
Mailing Address:		
Email Address:		
Best Contact Numbers:	Cell#:	Home#:

Primary Physician:		Telephone:	
Physician's Address:			

Insurance Information

Insurance Carrier:	
Primary Holder Name:	
Member #:	
Group #:	

Emergency Contacts

Although we never anticipate an emergency, in the event there is an emergency and we are unable to reach the parents/guardians listed, Amazing Kidz Therapy may contact the individuals below regarding your child:

Name:		Phone#:	
Name:		Phone#:	

Consent to Treat

I hereby authorize Amazing Kidz Therapy, PLLC and their therapists to perform evaluations and/or treatment to my child.

Parent/Guardian Signature: ________________________________ Date: __________________

Release of Information

I hereby authorize Amazing Kidz Therapy, PLLC to obtain and release information regarding my child to all listed insurance carriers. In addition, Amazing Kidz Therapy, PLLC may release and discuss information regarding my child, including but not limited to, evaluations, reports, progress notes and records, to the following organizations, practices and / or individuals:

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Emergency Care

In case of medical emergency, due to illness or injury during the process of receiving services, or while on property, I authorize Amazing Kidz Therapy, PLLC to:

1. Secure, provide and retain medical treatment and transportation if needed.
2. Release client records upon request to authorized individual or agency involved in the medical emergency treatment.

Any and all costs for emergency medical care will be the responsibility of the parent/guardian of the child including, but not limited to transportation, urgent care and medical treatment.

Parent/Guardian Signature: ________________________________ Date: __________________

Financial Responsibility

We will verify your coverage and bill in network insurance carriers on your behalf. However, you are ultimately responsible for any co-payment, any deductible / coinsurance / any amount not covered by your insurer at the time of service. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. All copayments/coinsurance must be paid at the time of service. Should an invoice be issued, said invoice must be paid by the due date. Patients with past due accounts will not be scheduled until their account is paid in full. For your convenience, we accept cash, checks and most major credit cards. Payments are also excepted through the Fusion portal. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25, in addition to any costs assessed or charged by any depository institution. Checks $300 and over will be charged 10% of the amount of the check surcharge.

Parent/Guardian Signature: ________________________________ Date: __________________

Medical History

Pre-Natal & Birth History

Did the mother/child receive pre-natal care throughout the pregnancy?	Y	N
Were there any notable complications during pregnancy?	Y	N

If yes, please explain:	

Delivery Method:	Vaginal	C-Section	Term of Pregnancy at the Time of Delivery in Weeks:	
Complications following delivery, including NICU & time in hospital:				

Developmental Milestones

Please give the approximate age that your child preformed the below. If an event has not yet occurred, please denote with N/A.

Milestone	Age in Months	Milestone	Age in Months
Smiled		Stood Alone	
Looked at Your Face		Walked	
Tracked Object with Eyes		Spoke First Word	
Ate Solid Food		Put Two Words Together	
Held/Picked Up Objects		Used Short Sentences	
Clapped Hands		Fed Self	
Rolled Over		Undressed Self	
Sat Alone		Dressed Self	
Crawled		Control of Bladder	
Held Own Bottle		Control of Bowels	

Primary Concerns

Please describe in two or three sentence the reasons for your visit.

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Revised 11/05/2020

Diagnoses

Please list all diagnoses that have been given to your child & the approximate date in which they were made.

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Specialty Care

Please indicate if your child has ever been seen or evaluated by the following healthcare specialists.

SPECIALTY	PROVIDER	DATES	CURRENTLY IN CARE	
Neurologist			Y	N
Cardiologist			Y	N
ENT			Y	N
Developmental Pediatrician			Y	N
Orthopedic			Y	N
Behavioral Specialist			Y	N
Occupational Therapist			Y	N
Physical Therapist			Y	N
Speech/Language Pathologist			Y	N

Surgeries/Hospitalizations

Please list any surgeries or hospitalizations, as well as dates, that your child has had.

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Medications

Please list all current medication and dosage that your child currently takes.

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Allergies

Please list any and all allergies that your child may have. If they and/or you carry an EpiPen, please indicate that below.

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Sensory

Does your child have any hearing difficulties?	Y	N	Does your child have any low vision difficulties?	Y	N

Please list any sensitivities that your child may have (i.e. certain sounds that may cause distress):

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Cancellation/No Show/Late/Sick Policy

Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies, illness, scheduled vacations, long weekends, or other unforeseen circumstances. When an appointment is not canceled with advanced notice you may be preventing another child from receiving therapy. For this reason, any appointment not cancelled with a minimum of 24 hours advanced notice a fee of $35 will be charged; this will not be covered by your insurance company and is a required out of pocket expense. In addition, should you cancel more than 3 appointments with less than 24 hours' notice in a 30-day period or accrue more than a 25% cancelation rate in a 3-month period your time slot will be forfeited to allow other children the opportunity to receive services.

During the holiday weeks of Thanksgiving and Christmas, we staff our office based on your commitments to your time slots during that week. Therefore, late cancelation fees for these holiday weeks will be $45.

No Show Policy

Failure to attend an appointment with any notice or cancellation will result in a No-Show Visit Fee of $60. Two consecutive no show appointments or more than two in a 30-day period will result in a forfeiture of your time slot to allow other children the opportunity to receive services.

Late Arrival Policy

We understand that delays can happen, however, in an effort to deliver quality care for your child and maintain other client's appointment times, children arriving more than 10 minutes late for a 30-minute appointment, 20 min late for a 45-minute appointment or 30 minutes late for an hour appointment may forfeit their appointment for the day at the discretion of the therapist. In addition, should your child arrive more than 10 minutes late for 2 consecutive therapy sessions a $15 late fee will be charged for each occurrence.

It is the policy that all parents/guardians/adult transporting child to their therapy appointment, remain on premises for the duration of your child's therapy session. Should this policy be broken without prior consent from Amazing Kidz Therapy, this may lead to a forfeiture of your time slot. In addition, should this policy be broken and there is no responsible party able to receive the child at the end of the therapy session it will affect other children's therapy times and sessions. Therefore, a fee of $10 for each 5-minute block of time will be charged until the child is retrieved.

Sick Policy

To keep all our friends healthy, we ask all visitors, including clients, parents, and siblings, to adhere to our sick policy. We ask that no one enters the building until being symptom free from all viral and bacterial illness for a minimum of 48 hours. This includes fever, vomiting, diarrhea, green nasal drainage, eye drainage, and / or on antibiotics for a minimum of 24 hours for all contagious diagnosis.

Revised 11/05/2020

COVID-19 Sick Policy

If anyone within your household has been confirmed positive or is suspected to be positive, or has been in contact with anyone confirmed positive or is suspected to be positive, to have COVID-19, or if anyone in your household has had a fever, cough, respiratory symptoms (including sinus congestion) within the last 14 days, you ***must*** change your appointment(s) to Teletherapy or cancel your in-person appointment(s) until they have completed their 14 day quarantine period.

Childs Name: ____

Parent/Guardian Signature: ______________________________________ Date: _____________

Media Release and Consent

Please choose ONE of the following options to indicate your preference for your child.

□ I hereby authorize Amazing Kidz Therapy, PLLC to photograph and/or videotape my child to utilize for any and all marketing, social media and/or publications as they see fit.

□ I hereby authorize Amazing Kidz Therapy, PLLC to photograph and/or videotape my child ONLY during group therapy treatment sessions, where my child will not be the only child within a picture, to utilize for any and all marketing, social media and/or publications as they see fit. I DO NOT authorize individual pictures of my child to be utilized.

□ I DO NOT authorize Amazing Kidz Therapy, PLLC to utilize any photographs of my child for marketing, social media or other purposes.

Childs Name: ____

Parent/Guardian Signature: __________________________________ Date: ____________

Parent/Guardian Printed Name: ____

Relationship to Child: ____

Release for Appointment Reminders

I, _____________________________________ (Print), hereby authorize Amazing Kidz Therapy, PLLC to send mean appointment reminder via e-mail or text message using the following information:

Email and/or text message reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Depending upon Cell Phone service provider and personal calling/messaging plan, text messaging rates may apply and are the responsibility of the Patient/Guardian listed below.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: ____

Cell phone: ____

Patient / Guardian (Print): ____

Signature: ____

Date: ____

Note to Office Managers: Confirm that the E-mail and Cell Phone provided above match the information in the patient information screen.

Waiver and Release of Liability

In consideration of the risk of injury while participating in therapy treatment and services (the "Activity"), and as consideration for the right to participate in the Activity, I hereby, for myself and my child, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my child's participation in therapy services, in both individual and group settings, and do hereby release and forever discharge Amazing Kidz Therapy, PLLC, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors, and assigns, for any physical or psychological injury and/or illness that my child may suffer as a direct result of their participation in the aforementioned activity.

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Amazing Kidz Therapy PLLC has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19. I further acknowledge that Amazing Kidz Therapy PLLC cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, and other clients and their families. I voluntarily seek services provided by Amazing Kidz Therapy PLLC and acknowledge that I am increasing my/child's risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I agree to indemnify and hold harmless Amazing Kidz Therapy, PLLC against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone else on behalf of my child, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by myself or anyone else on behalf of my child and will be held responsible for any and all financial expenses incurred by Amazing Kidz Therapy, PLLC.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written construed and enforced as so limited.

Childs Name: ____

Parent/Guardian Signature: ____________________________ Date: ____________

Parent/Guardian Printed Name: ____________________________________

Relationship to Child: ____