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

Primary Insurance

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

Secondary Insurance

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

Revised 11/2023

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:

_____

_____

_____

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 insurance 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 prior to the start of each therapy session. Services will not be rendered until proper payment is received.

If you change your insurance at any time it is your responsibility to notify our office. Failure to do so prior to therapy services being rendered will result in either a $15 administrative fee per claim to be submitted to your new insurance carrier OR the claim will be your full responsibility at the denied claim rate.

Should any claims be denied, for any reason, it is the responsibility of the policy holder to work directly with their insurance company to correct the issue. Additionally, any discrepancies in your policy vs how your insurance company is processing your claims will be your responsibility to work directly with your insurance company to resolve.

Should an invoice be issued, the balance of the invoice will be due at the time of your next visit. All invoices will be sent electronically to the email provided on your account and are available for review on the Patient Portal. Please note that payments not received by stated due date will result in a $25 late fee if the invoice total is less than $300 and 10% of the total amount due for those over $300 for each 30-day period that payment is delinquent. Accounts that are past due will forfeit all future appointments until the account is back in good standing.

For any client utilizing a Gardiner Scholarship for payment, we require that you approve the invoices placed in the Gardiner system no later than 30 days from submission. Invoices not approved in the Gardiner system within 30 days will be removed from Gardiner processing and moved to client responsibility with a two-week payment requirement. Should your child's account be in the EMA system with Step Up for Students, you are required to request the service from us in the system prior to the time of the appointment.

For your convenience, we accept cash, checks and most major credit cards. Payments are also excepted through the Fusion Patient 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. In addition, any funds that are recouped via bank, credit card, etc that incur bank fees as well as administrative fees will be the client's responsibility.

Parent/Guardian Signature: _____ Date: _____

Privacy Within Our Facility

Given the sensitive nature of the treatment that is provided at Amazing Kidz Therapy, PLLC, as well as the fact that we have many open spaces within our facility in which more than one child may be receiving services at the same time, the following polices are that of the office:

1. No one is permitted beyond the waiting room area without consent or escort of facility staff. All children must be escorted by parent or guardian to the bathroom when outside of treatment time.
2. Only one adult is permitted to attend the session with a child at a time. Siblings are welcome in our waiting room with supervision, but are not permitted into treatment sessions.
3. No pictures or videos are allowed within our facility without the explicit permission of the staff member in which the child is interacting.
4. No cell phone use (phone calls, work related, speaker phone) is permitted beyond the waiting room area. Should you need to take or make a phone call please use either the waiting room or the outdoor area. This includes hallways and restrooms. This is disruptive to services being rendered. Speaker phone use is not permitted in the facility at all, in any area.
5. Should any of these policies be broken, we reserve the right to remove you from our facility.

At the conclusion of each session, therapists will speak with the parent or guardian of the child to inform them of what was completed in the session as well as any follow-up work that therapist is recommending be completed at home. Most of these conversations will occur within the waiting room area. All parents are encouraged to ask for a private space should they want to speak with the therapist outside of the waiting room area for increased privacy.

We ask that all visitors respect and maintain the privacy of all other clients and their families.

Parent/Guardian Signature: _____ Date: _____

Documentation Requests

Any and all requests for the release of documents/medical records that are outside of the Patient Portal must be done in writing with our front desk. Please note that processing of all requests may take up to 7-10 business days.

Civility Clause

I understand that I am expected to treat the office staff and therapists in a civil manner. Un-civil behavior includes, but is not limited to, the use of vulgar, threatening or abusive language and/or actions. I understand that if I act in an un-civil manner towards the staff or therapists of Amazing Kidz

Therapy, PLLC., my child(ren) may be dismissed from services. In addition, I understand that this policy includes any and all adults that may bring my child to therapy as well as interact with the staff.

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 sentences the reasons for your visit.

_____

_____

_____

Diagnoses

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

_____

_____

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.

_____

_____

Medications

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

_____

_____

_____

Allergies

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

_____

_____

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):

_____

_____

_____

SOCIAL/FAMILY INFORMATION

Social/Relationship Concerns (i.e. friendships, extracurricular activities, sibling relationships, etc)

_____
_____
_____

Holidays

During various times throughout the year, our therapists may utilize themes for current events or holidays. In an effort to adhere to your family's beliefs and traditions, please list holidays that are observed by your family.

_____
_____
_____

Cancellation/Attendance/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. Monday appointments must be canceled by 5pm on the Friday before for non-emergent reasons to avoid a late cancellation fee. Should you cancel more than 2 appointments with less than 24 hours' notice in a 60-day period your time slot will be forfeited to allow other children the opportunity to receive services.

Failure to cancel a scheduled evaluation within 24 hours will result in a $35 administrative and rescheduling fee before the evaluation is rescheduled.

During the holiday weeks of Independence Day, 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.

Should cancellations exceed more than 2 consecutive weeks worth of appointments, reoccurring schedules will be removed from the schedule and the client will be moved to a Flex Schedule.

Should an appointment that is late canceled be rescheduled to another day within that calendar week, the appointment must be maintained or it will incur the late cancellation fee regardless of the circumstance or time frame prior to the appointment.

Please note that all cancellations, changes to appointments, and notifications of late arrivals MUST be made via telephone, or it will not be considered as received. Email notifications will not be accepted as there may be days and times that staff may not be in the facility or able to access email.

Attendance Policy

A minimum of 75% attendance must be maintained for each separate discipline. Failure to maintain a minimum of a 75% in a 3-month period will result in your child's time slot to be forfeited to allow other children the opportunity to receive services.

No Show Policy

Failure to attend an appointment without any notice or cancellation will result in a No-Show Visit Fee as follows:

- $60 for a 30 minute session
- $100 for a 60 minute session

Two no show appointments in a 3-month period will result in a forfeiture of your time slot to allow other children the opportunity to receive services. No Show visits are not eligible for rescheduling.

Failure to attend a scheduled evaluation will result in a $60 administrative and rescheduling fee before the appointment is rescheduled.

Late Arrival Policy

We understand that delays can happen, however, in a continued effort to deliver quality care for your child and maintain other client's appointment times, children arriving more than 15 minutes late for an appointment will forfeit their appointment for the day and be charged a Late Cancelation Rate. In addition, should your child arrive more than 7 minutes late for a therapy session a $15 late arrival fee will be charged.

Parent/Guardian On-Site Policy

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.

Parents/guardians must be in the waiting room at least 5 minutes prior to the end of the session time to allow for the therapist to review what was covered during the session as well as the activities to be carried over in the home. Our staff is not permitted to walk outside with your child.

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 24 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. **Please note, that our cancellation policy remains in effect regardless of the reason provided for the cancellation; 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.**

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 me 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: _____

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

We at Amazing Kidz Therapy, PLLC are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

Signature of patient or patient's representative/parent _____
Date _____
Printed name of patient or patient's representative/parent _____
Relationship to patient_____

HIPAA Notice of Privacy Practices

Amazing Kidz Therapy, PLLC, 687 W Lumsden Rd, Brandon, FL 33511

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other reuse required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, documentation requests from your insurance provider, communication with your listed primary care physician, and conducting or arranging for other business activities. For example, we may disclose your protected health information to students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you.

We may use or disclose your projected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law: Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164,500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or preceding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. Disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by email of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Service if you believe your privacy rights have been violated. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before December 3, 2021. We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone number at 813-643-1389