Kirsch Therapy
Physical, Occupational & Speech Therapy

PATIENT INFORMATION

Date: _____

Child's Name: _____ Gender: _____

Date of Birth: _____

Address: _____

_____

Parent/Legal Guardian Name: _____

Address: _____

_____

Cell: _____ Home: _____

Email: _____

Date of Birth: _____ SSN: _____

Driver's License: _____ State: _____

Parent/Legal Guardian Name: _____

Address: _____

_____

Cell: _____ Home: _____

Email: _____

Date of Birth: _____ SSN: _____

Driver's License: _____ State: _____

Insurance Carrier: _____

Policy Number: _____

Responsible Party: _____

Primary Care Physician: _____

Medical Group/Office Name: _____

Referred By: _____

1949 Avenida del Oro Ste. 118 Oceanside, CA 92056 Phone: 760-945-6500 Fax: 760-945-6535
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INTAKE QUESTIONNAIRE

1. What are your concerns with your child's development? Check all that apply:

   ☐ Speech/communication. Please explain: _____

   ☐ Feeding/eating/drinking. Please explain: _____

   ☐ Dressing/bathing/toileting. Please explain: _____

   ☐ Behavior/emotional regulation. Please explain: _____

   ☐ Coordination. Please explain: _____

   ☐ Other. Please explain: _____

   _____

2. How much of your child's speech do you understand? _____ %

   How much of your child's speech do other people understand? _____ %

   Is there a family history of speech delay? _____ Yes _____ No

   If yes, whom: _____

   Any additional information: _____

   _____

3. Please list any pregnancy complications: _____

   _____

   How many weeks gestation was the pregnancy? _____

   Please list any birth complications: _____

   _____

   Did you have a C-Section: _____ Yes _____ No

   Child's birth weight: _____ Child's APGAR score: _____

4. Did your child require any special care following birth? (Examples: NICU, oxygen, intensive care, tube feeding, etc.)? _____ Yes _____ No

   If yes, please explain: _____

   _____

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5. Was your child breastfed? _____ Yes _____ No If so, until what age? _____

   Was your child bottle fed? _____ Yes _____ No If so, until what age? _____

   Any difficulties with feeding? _____ Yes _____ No

   If there were feeding difficulties, please explain: _____

   _____

   Did your child take a pacifier and/or suck their thumb past 1 year of age? ____ Yes ____ No

   If yes, until what age did your child stop using a pacifier or sucking their thumb? _____

6. When did your child:
   Roll over: _____
   Sit unsupported: _____
   Crawl: _____
   Say first words: _____

*If you're unsure about the above, please state whether your child was early, late or on time with the listed milestones. _____

7. Does your child often trip/fall/injure themselves? _____ Yes _____ No

   If yes, please explain: _____

   _____

8. Has your child had their vision checked: _____ Yes _____ No

   If yes, when was the test? _____

   What were the results? _____

9. Has your child seen the dentist? _____Yes _____ No

   If yes, has your child had any dental procedures? _____ Yes _____ No

   If yes, please explain: _____

10. Has your child had their hearing checked: _____ Yes _____ No

    If yes, when was the test? _____

    What were the results? _____

11. Has your child had any ear infections? _____ Yes _____ No

    If yes, how many? _____

    Do they have tubes in their ears? _____ Yes _____ No

    If yes, when were the tubes placed? _____

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12. Are your child's immunizations up to date? _____ Yes _____ No

    If no, please explain: _____

    _____

13. Is your child taking any medications (including prescriptions, vitamins, homeopathic remedies, etc.)? _____ Yes _____ No

    If yes, please list below.

Name	Dose	Reason

14. Does your child have any allergies (including food allergies)? _____ Yes _____ No

    If yes, please explain: _____

    _____

15. Has your child ever been hospitalized? _____ Yes _____ No

    Has your child ever had surgery or a major accident? _____ Yes _____ No

    If yes to either of the above, please explain: _____

    _____

16. Has your child been diagnosed with ADHD, ODD, Autism Spectrum Disorder, Seizures, Dyslexia, Learning Disability, Intellectual Disability, Hearing Loss, Developmental Delay or any other illness, disease or syndrome? _____ Yes _____ No

    If yes, please list: _____

    _____

Is there a family history of ADHD, ODD, Autism, Seizures, Dyslexia, Learning Disability, Hearing Loss, Developmental Delay or any other similar illness, disease or syndrome?

_____ Yes _____ No

If yes, please explain: _____

_____

17. With whom does the child live?

Name	Age	Relationship

18. Are there any custody issues we should be aware of? _____ Yes _____ No

If yes, please explain: _____

_____

19. Are any other languages spoken in the household? _____ Yes _____ No

If yes, what language(s) _____

How often/What percent of the time and by whom?

_____

20. Does your child attend daycare, preschool or school? _____ Yes _____ No

If yes, where does your child attend? _____

How many days per week? _____

Please describe any academic performance concerns: _____

_____

_____

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21. Do you have any concerns regarding your child's social skills?

_____ Yes _____ No

If yes, please explain: _____

_____

22. Does your child display any unusual or repetitive behaviors?

_____ Yes _____ No

If yes, please explain: _____

_____

23. Do you have any behavioral concerns? _____ Yes _____ No

If yes, please explain: _____

_____

24. Has your child ever been enrolled in other therapies? _____ Yes _____ No

If yes, what therapy? _____

Where? _____

When? _____

25. Is your child a picky eater? _____ Yes _____ No

Do they eat a variety of fruits, vegetables and meats? _____ Yes _____ No

Does your child eat the same meal as the family? _____ Yes _____ No

Are they sensitive with certain textures? _____ Yes _____ No

If yes, please explain: _____

_____

Will your child over-stuff, gag, spit or cough when eating or drinking?

_____ Yes _____ No

If yes, please explain: _____

_____

26. Do you have any other concerns? _____ Yes _____ No

If yes, please explain: _____

_____

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HIPAA REALEASE OF INFORMATION

Under the Health Insurance Portability and Accountability Act (HIPAA), we cannot give patient health information without written consent. This release form allows the exchange of information between two parties.

Please complete this form if you (the parent/legal guardian) would like a copy of your child's medical reports from Kirsch Therapy. This form can also be used to allow Kirsch Therapy to send and receive the patient's medical information and treatment program(s). While it is not necessary to complete this document to send information to your child's primary care physician, it is required for us to provide information to all other providers.

This release is valid for one year and may be cancelled in writing at any time.

I authorize: Kirsch Therapy

To release: Medical Reports

For: _____
Patient's name

Date of Birth:_____

To: _____
Name of Parent(s)/Legal Guardian(s)

_____
Address and/or Fax Number

_____
City, State, Zip Code

_____
Email address if electronic copy requested

Patient/Legal Guardian Signature: _____ Date: _____

Relationship: _____Witness: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Under the Health Insurance Portability and Accountability Act (HIPAA), we cannot give patient health information to individuals **other than the parent or legal guardian** without written consent. If you wish to have your child's medical information **discussed** with other individual(s), please complete the section below. This authorization will allow **Kirsch Therapy** to discuss information only to those individual(s) listed below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on prior consent.

I authorize **Kirsch Therapy** to discuss my child's medical circumstances and conditions, including but not limited to goals, progress and test results, to the following individuals:

1. _____ Relationship to Patient _____

Phone: _____ Email_____ Fax _____

2. _____ Relationship to Patient _____

Phone: _____ Email_____ Fax _____

This authorization covers all medical information prior to and up to one year after the date this Authorization is signed.

Parent/Legal Guardian Signature: _____ Date: _____

AUTHORIZATION TO LEAVE VOICE MAIL/TEXT MESSAGES

It may be necessary for representatives of **Kirsch Therapy** to leave messages for patients. The purpose of the messages includes (but is not limited to) appointment reminders, testing results, or to ask a parent or legal guardian to call the office regarding an issue or concern. At no time will a representative discuss your medical circumstance or condition without your consent. **The purpose of this consent is to authorize us to leave messages with you or consented individual(s). Please indicate below the phone number(s) where we may leave messages.**

You have the right to revoke or change this consent at any time, in writing, except where we have already made disclosures in reliance on your prior consent.

Name: _____ Number: _____

Name: _____ Number: _____

Parent/Legal Guardian Signature: _____ Date: _____

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CONSENT TO TREAT

1. _____The undersigned consents to the treatment which will be provided during therapy, evaluations and treatments.
2. _____The undersigned understands that as part of healthcare, health records describing health history, symptoms, test results, diagnoses, treatment, and recommendations for future care, treatment and referrals will be generated. How this information can be disclosed including for treatment, payment and health care operations is described by the Health Insurance Portability and Accountability Act (HIPAA).
3. _____The undersigned authorizes direct payment to Kirsch Therapy of any health benefits otherwise payable to or on behalf of the undersigned for services provided through this clinic. Should direct payment of health benefits not cover all charges, if the services are not covered under insurance, if the services have not been otherwise approved for payment by insurance or should payment be denied by the insurance company or payer, it is understood by the undersigned that they are financially responsible for any remaining balance.
4. _____If home visits are being provided and the client is not available by 10 minutes after the scheduled meeting time and has not attempted to notify the office, the full treatment rate will be billed to the undersigned.
5. _____You must notify the office of any cancellations 24-hours before the appointment. If you do not call to cancel you will be charged $50.00.

The undersigned certifies that they have read the entire document and is the patient's parent or legal guardian or is duly authorized as the patient's general agent to execute the above and accept its terms.

Parent/Legal Guardian Signature: _____ Date: _____

Relationship: _____ Witness: _____

TELEPRACTICE INFORMED CONSENT FORM

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Telepractice is the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation. This service delivery model is supported by California's licensing board, the American speech-language, physical and occupational therapy boards, and is payable by most insurance carriers. Telepractice is viewed as a mode of delivery of health care services, not a separate form of practice. The standard of care is the same whether the patient is seen in-person, through telehealth (telepractice) or by other methods of electronically enabled health care. The therapist is able to perform diagnostic assessments and treatment. Kirsch Therapy offers telepractice therapy services through the live video conferencing software platform Insig. Insig is a HIPAA compliant secure health care virtual platform which protects the confidentiality of patient identification and data and against intentional or unintentional corruption. To access these services, a secure link will be sent to you via text, email, or both. Your therapist will join the appointment when services are ready to be provided. The practitioner and the client will be able to see and hear each other in real time. To participate in these services, please consent to the following:

1. I understand that "telepractice" includes diagnosis and treatment using interactive audio, video, or data communications. I understand that telepractice also involves the communication of my medical information, both orally and visually.
2. I understand that the standard of care is the same whether the patient is seen in-person or through telepractice and that I will be notified immediately if it is determined that this delivery model is not appropriate for the patient.
3. I have the right to withhold or withdraw consent to participate in telepractice at any time without it affecting my right to future care or treatment but that the care or treatment may not be available through Kirsch Therapy.
4. I understand that healthcare information may be shared with other individuals for the purposes of scheduling, billing, and in implementing a patient's plan of care and that these individuals involved will at all times maintain confidentiality of the information obtained and the laws that protect privacy and confidentiality of medical information equally apply to telepractice.
5. I understand that I am responsible for providing the necessary computer, telecommunications equipment (camera and microphone) and internet access for my telepractice sessions.
6. I understand that for certain patients, an adult facilitator will be required to be present in the room and assisting.
7. I understand that I am responsible for arranging a quiet location with sufficient lighting and privacy that is free from distractions or intrusions for the telepractice session to the best of my ability. Children should be in a common area or have the door to the room they are in open during all telehealth sessions.
8. I understand that Kirsch Therapy's payment policy is the same for telepractice appointments as in-person appointments. Kirsch Therapy does not guarantee any payment by insurance companies. The patient is responsible for the payment of all services rendered. As a courtesy

Kirsch Therapy will bill insurance companies. Some insurance companies are waiving co-payments for telehealth sessions. Check with your individual insurance company and ask about your specific benefits.

9. I understand that there are benefits, risks, and possible consequences associated with telepractice, including, but not limited to, the possibility, despite reasonable efforts on the part of Kirsch Therapy, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Kirsch Therapy has all safeguards in place to protect patient information and provide HIPAA compliant services. To best protect your digital information, you should always install all computer updates and keep up-to-date virus protection on your devices.

I have read and understand the information provided above and have had my questions answered to my satisfaction. I have read this document carefully, and understand the risks, benefits, and my rights related to the telepractice and I am hereby electively giving my informed consent to participate in a telepractice service through Kirsch Therapy under the terms described herein. I hereby state that I have read, understood, and agree to the terms of this document.

Name_____ Date_____

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CREDIT CARD AUTHORIZATION

Please complete the following information. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type (circle one)	Visa MasterCard
Card Number	
Security Code	
Expiration Date (mm/yy)	
Name as Printed on Card	
Patient Name and DOB	
Billing Address (Street, City, State & Zip)	

I, _____, authorize Kirsch Therapy to
(print name)
charge my credit card for any fees, whether presently due or due in the future, that I have agreed to in the Treatment Consent Form. These charges or fees may include, but are not limited to:

- $50 late cancellation fee or are more than 20 minutes late for half-hour appointments, or are more than 40 minutes late for one-hour appointments;
- $25 fee for any declined credit card charge; and
- any and all amounts due for treatment or services rendered to patient.

For treatment or services rendered, we will attempt to bill the patient's insurance, if any. All remaining charges not paid by patient's insurance will be charged to your credit card on a weekly basis. Late cancellation fees are charged if the appointment is not cancelled at least 24 hours in advance or if the patient does not arrive to the appointment within 20 minutes of the appointment start time for half hour appointments/40 minutes of the appointment start time for one-hour appointments. Kirsch Therapy may waive the late cancellation fee in the event of emergencies or unforeseen circumstances. Late cancellation fees and declined credit card fees will be charged to your credit card weekly.

I authorize Kirsch Therapy to disclose information about my attendance/cancellation to my credit card company if I choose to dispute a charge.

Credit Card Holder's Signature: _____ Date:_____

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