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:

_____

_____

_____

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. For your convenience, we accept cash, checks and most major credit cards. 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: _____

Amazing Kidz Therapy, PLLC

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	

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):

_____

_____

_____

Cancellation/No Show/Late/Sick Policy

Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies, illness or other unforeseen circumstances. When an appointment is not canceled with advanced notice you may be preventing another child from receiving a therapy time. It is for this reason that any appointment not cancelled with a minimum of 24 hours advanced notice will be charged a $25 fee; this will not be covered by your insurance company and be required to be paid out of pocket.
In addition, should you cancel more than 3 appointments with less than 24 hours' notice in a 30-day period or more than a 25% cancelation rate in a 6-month period your time slot will be forfeited to allow other children the opportunity to receive services.

No Show Policy

Failure to attend an appointment with any notice or cancellation will result in a No Show Visit Fee of $40. 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 time, 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 $10 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

In order 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 form 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.

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 that my child may suffer as a direct result of their participation in the aforementioned Activity.

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: _____