PATIENT REGISTRATION FORM

Kidz Therapy Zone
1101 Central Expressway S. Suite 185
Allen, TX 75013
Phone (214) 509-6961
frontdesk@kidztherapyzone.com

DATE:	☐ Initial Evaluation	☐ Annual Evaluation	☐ General Update

PATIENT INFORMATION:			
Last Name:	**First Name:**	**MI:**	
Date of Birth:	**Age:**	☐ **Male** ☐ **Female**	
Street Address:	**City:**	**State/Zip:**	
School District:	**School:**	**Grade:**	

PARENT/GUARDIAN INFORMATION:			
Mother's Full Name:		**Lives with patient:** ☐ **Yes** ☐ **No**	
Street Address: (if different)	**City:**	**State/Zip:**	
Cell Phone Number:	**E-mail address:**		
Employer:	**Work Number:**	**Home Number:**	
Father's Full Name:		**Lives with patient:** ☐ **Yes** ☐ **No**	
Street Address: (if different)	**City:**	**State/Zip:**	
Cell Phone Number:	**E-mail address:**		
Employer:	**Work Number:**	**Home Number:**	
Primary Contact:	**Best Way to Reach You:** ☐ **Cell** ☐ **Work** ☐ **Home** ☐ **E-mail**		

INSURANCE INFORMATION – Please select one: ☐ Using Insurance ☐ Self-pay		
Subscriber's Name:	**Date of Birth:**	**Relation to Patient:**
Insurance Company:		**Insurance Telephone Number:**
Policy Number:	**Group Number:**	**Effective date:**
Secondary Insurance:		**Insurance Telephone Number:**
Policy Number:	**Group Number:**	**Effective date:**

Who referred you to Kidz Therapy Zone (e.g., physician, teacher, etc.)?

A. MEDICAL INFORMATION:

Primary Care Physician: **Telephone #:**

Please list any other specialists and office numbers:

Please list any known medical diagnoses/disabilities (e.g., Autism, Down's Syndrome, ADHD, etc.) AND Date of Onset:

Immunization History: ☐ vaccinated on time ☐ delayed ☐ selective ☐ did not vaccinate

Hearing Screening: ☐ Pass ☐ Fail **Date screened:** ***current results required**
Vision Screening: ☐ Pass ☐ Fail **Date screened:** **for speech testing**

Please indicate if your child uses any of the following supports:
☐ Glasses/contacts ☐ Hearing Aids ☐ Cochlear Implant ☐ FM System ☐ Feeding Tube
☐ Wheelchair ☐ Walker ☐ Shoe Inserts ☐ Augmentative Communication Device
☐ Braces or Splints ☐ Other (please list):

Is your child currently taking medications or supplements? If yes, please list name and dosage below:
☐ Yes ☐ No

Does your child have any known allergies? If yes, please list and describe safety/emergency information (e.g., epi pens, inhalers, etc.): ☐ Yes ☐ No

Does your child have seizures? If yes, please describe type and possible triggers (e.g., spinning, flashing lights, iPad, etc.) below: ☐ Yes ☐ No

***If your child does have seizures, please provide a copy of their formal seizure safety plan**

If your child has seizures, do they have a physcian's clearance for rotary input/spinning? ☐ Yes ☐ No

Please list any additional medical/safety precautions:

B. PRENATAL/BIRTH HISTORY/DEVELOPMENTAL HISTORY

Labor and Delivery:			**Maternal prenatal concerns/complications:**					
Full Term Birth:	☐ Yes	☐ No	**Diabetes:**	☐ Yes	☐ No	**Rash:**	☐ Yes	☐ No
Pre Term Birth:	☐ Yes	☐ No	**Bleeding:**	☐ Yes	☐ No	**Fever:**	☐ Yes	☐ No
Small for gestation:	☐ Yes	☐ No	**Hypertension:**	☐ Yes	☐ No	**Toxemia:**	☐ Yes	☐ No
Birth length:			**Trauma:**	☐ Yes	☐ No	**Alcohol Use:**	☐ Yes	☐ No
Birth weight:			**Medications:**	☐ Yes	☐ No	**Tobacco Use:**	☐ Yes	☐ No
Forceps:	☐ Yes	☐ No	**Infections:**	☐ Yes	☐ No	**Drug Use:**	☐ Yes	☐ No
Cesarean Section:	☐ Yes	☐ No	**Other:**					
If yes:	☐ Emergency	☐ Planned						

C. NEONATAL HISTORY/EARLY DEVELOPMENT:					
Appropriate HT/WT/head circumference:	☐ Yes	☐ No	Did not like being cuddled:	☐ Yes	☐ No
Respiratory distress/oxygen:	☐ Yes	☐ No	Excessive quietness:	☐ Yes	☐ No
Hypoglycemia/coma:	☐ Yes	☐ No	Colic after 2 months:	☐ Yes	☐ No
Apnea/seizures:	☐ Yes	☐ No	Hyperactivity/irritability:	☐ Yes	☐ No
Jaundice:	☐ Yes	☐ No	Altered sleep/wake cycles:	☐ Yes	☐ No
Feeding problems:	☐ Yes	☐ No	Floppiness:	☐ Yes	☐ No
Passed newborn hearing/vision screenings:	☐ Yes	☐ No	Stiffness:	☐ Yes	☐ No
Other neonatal concerns:			Duration of hospital stay:		

D. DEVELOPMENTAL MILESTONES:	
Indicate approximate age at which milestones were reached.	
Crawling:	Sitting (unsupported):
Walking:	Talking (single words):
Talking (phrases/short sentences):	Toilet training:

E. FAMILY INFORMATION:

What languages are spoken at home? If multiple, what is your child's primary language?

Please indicate family history of the following:

☐ Learning disability ☐ Language delays ☐ ADHD ☐ Autism ☐ Stuttering
☐ Seizures ☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Suicide
☐ Other (please list):

Please list sibling names and ages:

Please indicate if any of the following circumstances occurred (which you believe may have affected your child's development):

☐ Divorce/separation ☐ Death of family/friend ☐ Relocation ☐ New baby ☐ Illness/hospitilzation
☐ Other (please describe):

F. THERAPEUTIC HISTORY:

Has your child received private or home health therapy services in the past? ☐ Yes ☐ No
If yes, please list Facility/Company, Duration of therapy, frequency, and type of service.
(e.g., "Kidz Therapy Zone – Jan. 2016-Dec. 2016 – 2x/wk – speech and occupational therapy")

(*please list school therapy under section G)

Please list any additional private/home health therapy services that your child <u>currently</u> receives, if any:

G. SPECIAL EDUCATION/504 - *Skip this section if your child is not enrolled in public school*

Was your child ever tested for special education or 504 services? ☐ Yes ☐ No

Has your child met eligibility for special education or 504 services? ☐ Yes ☐ No
If yes, please complete the remaining boxes on this section.

Please list disabilities and/or 504 eligibilities below (e.g., dyslexia, learning disability, speech impairment, etc.):

Please list type and frequency of services (e.g., speech 2x/wk, occupational therapy consult, social group, resource room, etc.):

When was your child's most recent Full Individual Evaluation (typically administered every 3 years)?

When was your child's current IEP developed (last ARD meeting)?

List any accommodations in your child's IEP or 504 Plan that you would like your therapist to be aware of:

Is your child in a self-contained classroom? ☐ Yes ☐ No

Does your child have an accompanying Behavior Intervention Plan? ☐ Yes ☐ No

H. BEHAVIORAL INFORMATION:

Please list some of your child's interests (e.g., toys, activities, characters, etc.):

Please list any items/activities that your child doesn't like/avoids:

Please indicate if your child exhibits any of the following behaviors:

☐ Poor focus/attention	☐ Inability to sit still	☐ Poor eye contact	☐ Mood swings
☐ Hitting/kicking	☐ Throws objects	☐ Spitting	☐ Verbal outbursts
☐ Frequent tantrums	☐ Self-injurous behavior	☐ Difficulty with transitions	☐ Impulsive

☐ Other (please list):

Do you notice an increase in problem behaviors when there is a change in routine? ☐ Yes ☐ No

Does your child engage in repetitive behaviors (e.g., hand flapping, spining, etc.)? ☐ Yes ☐ No
If yes, please describe:

Does your child engage in unusual behaviors (e.g., lining up objects, licking, sniffing items, holding items in hand, etc.)? If yes, please describe: ☐ Yes ☐ No

Does your child receive ABA services, or have they in the past? ☐ Yes ☐ No
If yes, please name facility/office and length of treatment:

I. AUTHORIZATION TO TREAT PATIENT

I agree to give "KIDZ THERAPY ZONE" consent for care and treatment considered necessary and proper in evaluation and treating my condition. I authorize "KIDZ THERAPY ZONE" to treat me and use my personal health information for healthcare operations. I have reviewed the posted HIPPA privacy policy and a copy of the policy has been offered to me.

I agree my insurance benefits have been verified by "KIDZ THERAPY ZONE" and have been explained to me from the information collected by my insurance plan. However, the information that was given by the insurance: by paper, by insurance recorder or by representative over the phone is "NOT A GUARANTEE OF PAYMENT". Verification is a courtesy by our clinic and we cannot be held responsible for the benefits told. We do ask that our client's insured also call their insurance to verify coverage.

Signature (Parent or Insured) _____ Date:_____

J. RELEASE

Permission is specifically granted to release information to: your insurance for billing purposes and to your doctor who referred your child for treatment. But, if you have any other releases you want approved, please list below (e.g., treating therapist, teachers, physicians, other insurance companies etc.):

Name:	
Address:	
Title:	
Phone:	

Name:	
Address:	
Title:	
Phone:	

☐ I do NOT give permission for Kidz Therapy Zone LLC to release information regarding my child.

☐ I give permission for Kidz Therapy Zone LLC to release information regarding my child when necessary.

☐ I give Kidz Therapy Zone permission to post a picture of my child on the bulletin board in our office.

Please indicate if someone other than a parent/legal guardian will be bringing your child to appointments:		
Name:	**Phone #:**	**Relation to child:**
Name:	**Phone #:**	**Relation to child:**
Do you give permission for Kidz Therapy Zone staff to discuss your child's therapy session with the individuals you have listed above? ☐ **Yes, I give my permission** ☐ **No, I do NOT give my permission**		

_____

Name Date

K. ATTENDANCE AND CANCELLATION

Effective care requires a commitment from the child's family. Regular attendance is necessary to therapy sessions to be meaningful and effective. Working together as a team, we can accomplish the best outcomes for your children and family. Reasons for absence should therefore be limited to parent or child illness or other family emergency situations.

If you or your child is ill, we prefer that you cancel rather than spread illness. 24 hour notice is required. If you miss an appointment without cancelling in advance you will be charged the full cost of your appointment. If your credit card is on file, it will be charged at the time of the missed appointment. If your card is not on file, payment for the missed appointment will be due at the time of your next visit.

If you are running late for your appointment please call. When you arrive your appointment will consist of the time left of the schedule appointment *unless* the schedule allows for the full scheduled amount of time. In either case the regular fee for the appointment will be charged.

_____ Please initial here indicating your acknowledgement of this policy.

If your child is absent from therapy frequently, it may be necessary for your therapist to discontinue your appointed time in order to make the time slot available to another patient. We encourage you to communicate frequently with your therapist in order to best accommodate your child's particular needs and try to prevent disruptions in your child's care.

L. FINANCIAL POLICIES

Payment is due at the time of service.

In a situation where the child's parents are divorced or separated, it is our policy that the parent who has arranged the sessions is ultimately the responsible party. We will require written authorization from the other party should they be intending to pay for the therapies. We will not bill another party (parent, grandparent) without their prior authorization.

Kidz Therapy Zone appreciates the confidence you have shown in choosing us to provide your health care needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. Your insurance is a method for you to receive reimbursement for fees you pay for therapy. Having insurance is not a substitute for payment. We typically have a fixed allowance or percentage we charge based on our contract with insurance companies. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid by your insurance which may include services verified by your insurance as being covered by your plan that are ultimately not covered by your insurance provider. Many insurance companies have additional stipulations that may affect your coverage. We will do our best to determine if there are exclusions on your policy and inform you of such findings; however, it is ultimately the patient's responsibility to know your coverage and benefits, but you are responsible for your child's bill if your insurance has not reimbursed Kidz Therapy Zone within 60 days of submission to them. Delinquent accounts will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees / attorney's fees.

It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at Kidz Therapy Zone.

Your initial below indicates you have read the Financial Policy explained above and assume full financial responsibility.

_____ Please initial here indicating your acknowledgement of this policy.

We have specific therapists perform initial evaluations. Based on the outcome of the evaluation we pair the therapist which will match best personality and skill level wise. We make every effort to ensure your child sees the same therapist every visit. However, there are those occasions when a therapist is ill or on vacation and another certified therapist will fill in temporarily. This is done automatically. Such cases are minimal.

_____ Please initial here indicating your acknowledgement of this policy.

M. NOTICE OF INFORMATION PRACTICIES AND PRIVACY STATEMENT

Kidz Therapy Zone LLC (KTZ) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between KTZ and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.kidztherapyzone.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of KTZ. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Please sign below indicating that you have read and understand these policies.

Name: _____

Name (Print): _____

Date: _____

N. OFFICE INFORMATION

When you first arrive at the office we ask you sign in at the receptionist's desk and notify us of any changes in address or insurance information.

We also request any co-payment or deductible be paid at this time. Payment is due at the time of service.

In order to retain a safe, clean and confidential office we have the following necessary office policies and courtesies.

O. FACILITY SAFETY:

NO ONE MAY ENTER THE TREATMENT AREAS UNDER ANY CIRCUMSTANCES unless accompanied by your child's therapist. This is not a request, but a firm policy. Our extensive equipment, while enticing, has its inherent dangers and precautions. This policy applies to everyone: parents, caregivers, patients, siblings and friends. No one is permitted to wander through our facility, nor to use any equipment during your child's treatment times.

We maintain a large, comfortable waiting room with a play area where parents, caregivers, siblings and friends may relax during the time when your student is with their therapist.

If a parent or caregiver is participating in the treatment session with your child and their therapist, it is still your responsibility to ensure that any siblings or friends who are present with you abide by these rules. It is for their safety, and necessary to protect us from possible liability. We need to focus our attention on your child during their treatment.

_____ Please initial here indicating your acknowledgement of this policy.

P. SNACKS AND THE WAITING ROOM:

Please keep snacks in the waiting room or take them with you as you exit. We understand that snacks and kids can be messy. For the comfort of all our patients we ask that you clean up if your child has created any food mess. And please do not bring in large, messy dinners like pizzas and meatball subs to eat while waiting for your child. Some children that come here are allergic to the smell and taste of peanuts so we ask as a courtesy that you please do not bring peanuts to the office.

Please treat our facility as you would your own home. If there are toys or food wrappers, dirty diapers or general mess that your family has created, please take the time to tidy up before you leave.

Q. CONFIDENTIALITY:

We make every effort to maintain confidentiality. Some of the treatment areas have more than one therapist and student participating at a time. No photographs of your child are taken nor will we contact any parties to discuss your child without written consent. If you prefer to have privacy when discussing your child, please ask therapist to talk in a private space rather than the waiting room.