Patient Information Form

Date: _____

Child's Full Name:_____ DOB:_____Age:_____ Sex:_____

Child's Address:_____City:_____State:_____Zip:_____

Guardian Name (1):_____Street Address:_____

City:_____State:____Zip:_____Email:_____

Cell Phone: _____

Guardian Name (2):_____Street Address:_____

City:_____State:____Zip:_____Email:_____

Cell Phone: _____

Primary Insurance: Company/Policy Number**:** _____

Secondary Insurance: Company/Policy Number: _____

Referring Physician/Pediatrician (Name/Facility): _____

Physician Phone:_____ Physician Fax:_____

Consent for Evaluation and Treatment

1. I authorize a therapist with Speech4Kidz to perform Occupational Therapy with my child. **Initials**_____

2. I authorize a student to be present in the room during therapy sessions for observation purposes. **Initials**_____

3. I authorize Speech4Kidz to text appointment changes or reminders. **Initials**_____

4. I understand it is my responsibility to contact my insurance to understand my copay, deductible and limits of my benefits. I am aware I will be held responsible for costs that exceed my plan. **Initials**_____

5. I understand it is my responsibility to inform the office immediately of any changes to address, insurance coverage, and general physician/pediatrician. Failure to do so could lead to claim denials for insurance. **Initials**_____

6. I understand that my child must be free of illness for 24 hours prior to scheduled appointments. This includes, but is not limited to diarrhea, vomiting, skin rashes, eye infections, and persistent coughing. **Initials**_____

7. Due to the personal nature of certain goals, I acknowledge that my presence may be required during my child's treatment. **Initials**_____

8. I understand that there is inherent risk of injury in certain activities and I agree to release Speech 4 Kidz, Inc. of all liability. **Initials**_____

Is this your child's first occupational therapy evaluation? ☐ **Yes** ☐ **No**

If no, when and where was previous?_____

Recommendations:_____

Does your child have an IFSP/IEP? ☐ **Yes** ☐ **No**

If so, how often is OT received at school (# of days per week)?_____

Release of Information Form

- I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, (Child's Name)_____to Speech4Kidz, Inc.. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Speech4Kidz, Inc. to contact any persons or institutions to obtain any additional information regarding my child when necessary.

  Signed_____
  (Guardian)

- I hereby authorize Speech4Kidz,Inc. to release therapy reports regarding my child (Child's Name)_____, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of_____.

  Signed_____
  (Guardian)

- I, _____, give my permission for Speech4Kidz, Inc. to photograph and/or videotape my child (Child's Name)_____, and use said photos/videos for promotional or teaching purposes.

  Signed_____
  (Guardian)

Payment Policy:

We require payment at the time of service.
If sufficient, up-to-date insurance information is not on file (including a full sponsor's SSN for Tricare patients), the entire fee is due at the time of service.
It is the parent/guardian's responsibility to notify us of any insurance changes. Failure to do so will result in out of pocket charges for all non-covered sessions.

For Medicaid beneficiaries: If the policy becomes inactive or changes, therapy will be placed on hold until we can obtain new authorization and/or proof of coverage.

Administration hours are to call for payment are, Monday- Thursday 8:30am- 4:30pm

Pay by phone: Wilmington 910.395.2995 / Jacksonville 910.353.2440

I understand that services not covered by my child's insurance policy are to be paid at the time of service and failure to pay this amount will result in suspension of services. In addition, I agree to provide Speech 4 Kidz, Inc. with current insurance information at all times.

Assignment of Payment:
I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to Speech4Kidz, Inc. to release information necessary to secure payment. I understand that I am financially responsible for all charges not paid by insurance and I agree to notify Speech4Kidz immediately of any insurance changes. I authorize Speech4Kidz, Inc. to receive direct payment for therapy services rendered to my child.

_____

Parent/Guardian Signature Date

CANCELLATION POLICY UPDATE

Speech 4 Kidz Inc appreciates you sharing and trusting us with the care of your child. An evaluation and plan of care is completed by one of our licensed therapists to address the medical necessity and needs of your child including a specific amount of time each week for progress towards goals. Parents, physician and insurance also agree to the plan of care created. Cancellations and No-Shows to scheduled therapy sessions not only impact this progress but also take away our ability to provide this service to another child with needs. Please help the Speech 4 Kidz team and your child by following our policy:

ATTENDANCE/ LATE CANCELLATION/ NO SHOW POLICY

No Show= missing a scheduled appointment
Late Cancellation=canceling an appointment after 3pm the business day prior to appointment.

2 No Shows is an automatic discharge from Speech 4 Kidz

There is a $25 No Show and Late Cancellation fee for EVERY scheduled therapy appointment with Speech 4 Kidz.
***We understand illness and minor emergencies do come up causing late cancellations. In these situations, the fee may be waived by our office. Rescheduling late cancellations for a future day is encouraged and will eliminate the $25 late fee for that session.

Speech 4 Kidz will remove clients who cancel frequently (up to 50% of scheduled monthly sessions) from their weekly slots placing client on a call as slots are available list each week.

Please check the box for both statements.

- ☐ **I understand the Speech 4 Kidz late cancellations/no show policy.**
- ☐ **I understand there is a $25 fee for no show/late cancellations that are not rescheduled.**

Parent Signature:_____ Date:_____

Personal Information:

☐ Both Parents ☐ Foster Parent(s) ☐ Adoptive Parent(s)
☐ Single Parent (which one?)_____ Other:_____

Primary Language Spoken in Home (circle one): ☐ English ☐ Spanish Other_____
Do any immediate siblings have any diagnosis or concerns?If so, what are they?
_____

Birth and Medical History:

Are there any notable issues during pregnancy? If yes, please explain. _____

Was your child premature (<36 weeks)? ☐ Yes ☐ No If yes, how many weeks?_____

Are there any other concerns that you think would be helpful for the therapist to know while evaluating?

Does your child have any concerns in the following areas?

☐ fine motor
☐ balance/coordination eating
☐ dressing
☐ self care (i.e. brushing teeth, bathing, using utensils)
☐ sensory
☐ social
☐ behavior

Does your child have any notable allergies?

Does your child have any dietary restrictions?

Does your child have any current psychological, medical or other diagnosis?

Diagnosis	Approximate Onset Date

Does your child take any daily medications?

Medication	Amount/Frequency

Developmental Milestones

Please list any developmental delays. I.e. skipped rolling or crawling, etc.

Additional Feedback:

Please explain any other concerns or information that you feel will be helpful for the therapist when evaluating your child.