Kidz Therapy Zone

Kidz Therapy Zone, LLC
1134 Kennebec Drive, Suite B
Chambersburg, PA 17201
(717) 446-0439 Office
(717) 312-8998 Fax
www.ktherapyzone.com

Date: _____

Demographic Form

Child's Name: _____ Child's DOB: _____

Mother Name: _____ Phone: _____

Father Name: _____ Phone: _____

If you are a guardian, do you have custody papers, DSS care, foster care, or power of attorney? Yes No
If yes, please provide a copy for our records.

Address: _____

City: _____ State: _____ Zip Code: _____

Who lives in the home with your child? _____

Primary Contact Number: _____ Secondary Contact Number: _____

Email Address: _____

Siblings (Ages): _____

Therapy Service of Interest: SOCIAL SKILLS OCCUPATIONAL PHYSICAL SPEECH

Primary Care Physician: _____ Phone: _____

Address: _____

Do you have a prescription from your child's Dr. for therapy? YES NO (Please provide a copy)

Primary Insurance Carrier Information:

Company: _____

Member ID #: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance Carrier Information:

Company: _____

Member ID #: _____

Policy Holder Name: _____ DOB: _____

Patient's Authorization for Treatment, Release of Information and Assignment of Benefits

I authorize treatment by Kidz Therapy Zone, LLC and certify that the information I have reported is correct. I further authorize the release of any necessary information, including medical information for this or any related claims to the insurance companies, other medical personnel involved in my care, law enforcement officials, or government programs. I hereby authorize that the interests of Kidz Therapy Zone, LLC be protected on all claims for services provided resulting from any type of accidental injury, event or occurrence. I hereby authorize Kidz Therapy Zone, LLC to apply for benefits on my behalf for covered services rendered by Kidz Therapy Zone, LLC I request payment from my insurance company be made directly to Kidz Therapy Zone, LLC.

I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time by giving timely written notice to the Medical Records Custodian at this office. I understand that I may not revoke this authorization for any actions taken prior to my written notice of revocation. I also understand that, if I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. If my account becomes assigned to a collection agency, I agree to pay the collection agency fee, court costs, and attorney fees. I also understand that I will pay an additional $35 for any check that does not clear the bank for any reason. I understand that I will be responsible for cancellation of any scheduled appointment 24 hours prior to that appointment; otherwise, I will be assessed a $35 non-refundable fee that will not be reimbursed by my insurance company.

Signature: _____ (seal) Date: _____

Patient's Notice of Privacy Practice Acknowledgement

A copy of the Notice of Privacy Practice is available at your request. It is also posted on our bulletin board located in Kidz Therapy Zone, LLC Lobby.

Signature: _____ (seal) Date: _____

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MEDICAL & DEVELOPMENTAL HISTORY

Were there any pregnancy complications? Yes No
Explain: _____

_____

Length of pregnancy: _____ Was prenatal care received? _____
Were there any delivery complications? Yes No
Explain: _____

_____

Did your child have any complications following delivery: Yes No
Explain: _____

_____

Does your child have any medical diagnoses: _____

_____

Past Medical History:
____ Allergies: _____
____ Seizures/type: _____
____ Accidents: _____
____ Operations/surgeries: _____
____ Chromosomal Disorders/Unusual Disease: _____
____ Hospitalizations: _____
____ Splint/brace/wheelchair/walker/etc.: _____
____ Hearing/vision Impairment: _____
____ Blood Pressure or Temp regulation difficulty: _____
____ Other: _____

Please list any medications, vitamins, or supplements the child is currently taking (or recently took, if pertinent): Medication Reason: _____

_____

Date of most recent hearing evaluation: _____ Did your child pass? _____
Do you have concerns with your child's hearing? _____

_____

Date of most recent vision evaluation: _____ Did your child pass? _____

Do you have concerns with your child's vision? _____

_____

Developmental History

How does your child communicate wants and needs? Please check all that apply.

Crying _____ Pulling/leading _____ One word _____ Long sentences _____ Pointing _____

Making sounds _____ Short sentences _____ Other: _____

Please circle an answer for the following statements:

Does your child fall or lose balance easily? (YES) (NO)

Child visually looks at people/toys? (YES) (NO)

Child shows negative response when touched or touching other objects? (YES) (NO)

Child enjoys movement such as swinging or roughhousing? (YES) (NO)

Child play/participate in leisure activities daily? (YES) (NO)

Do most people understand the child? (YES) (NO)

Does the child understand instructions? (YES) (NO)

Is your child fixated with something? (YES) (NO) Explain: _____

What is your child's favorite activities/characters?: _____

_____

What calms your child?: _____

_____

What do you wish to gain from therapy?: _____

_____

Parent/Guardian Signature: _____ Date: _____

PAYMENT FOR SERVICES AGREEMENT

Kidz Therapy Zone, LLC will provide therapy services for your child (patient) in accordance with the orders provided by the patient's physician. It is understood that licensed therapists employed by Kidz Therapy Zone, LLC will complete the services provided. The responsibly party gives permission for the patient to receive therapy services provided by Kidz Therapy Zone, LLC.

Kidz Therapy Zone, LLC will verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

The responsible party authorizes any insurance carrier that provides insurance coverage for the patient, to make direct payments to Kidz Therapy Zone, LLC for all services rendered. The responsible party will accurately inform Kidz Therapy Zone, LLC of the patient's insurance coverage and provide information regarding coverage changes within 5 working days of the change.

The responsible party authorizes the release of information pertaining to the patient's diagnosis and course of treatment to Kidz Therapy Zone, LLC by the patient's physician and any other therapy service providers involved in the patient's care. The responsibly party also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Cancelation/No Show Policy

If you No-Show for 3 consecutive appointments all future appointments will be forfeited. If you cancel your appointments for 4 consecutive weeks, your appointment time will be removed from our schedule. If you No Show and/or cancel in any combination for 4 consecutive weeks, your appointment time will be removed from our schedule. Kidz Therapy Zone, LLC will not guarantee time should you request services following removal from the schedule.

This policy is in place out of respect for the therapist and our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation/No Show Policy for Kidz Therapy Zone, LLC as described above.

Thank you for your understanding and cooperation.

Signature: _____ Date: _____

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Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Parent_____

[ ] Step-Parent/Guardian _____

[ ] Doctors _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

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Illness Policy

To assure that illness is not spread to others Kidz Therapy Zone, LLC has adopted the below policy.

Please contact the office if your child will be absent. If a child frequently misses therapy sessions, it may be advised to contact a physician to assure of medical stability before re-scheduling services.

Please cancel your session if your child has any of the following;

- Any temperature above 100 degrees without medication, child should be temp free for 24 hours
- Vomiting or diarrhea within the last 24 hours
- Rash on the body with no known reason
- Contagious illness;
  Pink eye, Hand Foot Mouth illness, Strep Throat, Chicken Pox, Mumps/Measles/Rubella, RSV, Hepatitis A infection, Pertussis
- Viral/Flu like symptoms (fever, vomiting, lethargy, body aches)
- Respiratory symptoms; frequent cough/nasal drainage

If your child is on an antibiotic, please refrain from services until they have taken their antibiotic for at least 24 hours.

If your child is prescribed an Inhaler, Oxygen, and/or Epi Pen – it must be available during therapy sessions. Administration would need to be provided by the parent or caregiver.

If you have any questions or concerns about the above policy, please speak with any of our staff members. Thank you for your cooperation in advance.