Patient Information:

Child's full name:_____ Date of Birth:_____ Age: _____ Sex: M / F

Address: _____ City: _____ State:_____

Zip:_____ Is the patient a foster child? _____Yes _____ No

Case Worker Name:_____ Phone:_____
County:_____

Additional information regarding care, contact, and restrictions:

_____

Guardian Information:

Guardian's Name (1):

_____

Address:_____ City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

E-mail:_____

Guardian's Name
(2):_____

Address:_____ City:_____ State:_____
Zip:_____

Home Phone: _____Cell Phone:_____

Work Pone:_____ E-mail: _____

Doctor Information:

Physician/Pediatrician (Name and Facility):

_____

Physician Phone Number: _____

Physician Fax Number: _____

Insurance Information:

** Please list *all* insurance plans for which the patient is a beneficiary, **even if you know that therapy will not be covered by this plan.**

Please note: If your child is covered by **Medicaid: Please include any and all commercial insurance policies that list your child as a beneficiary (i.e. Anthem, United Healthcare, Humana, Passport, Wellcare) in order to ensure that claims are processed appropriately.

Primary Insurance:

Policy Holder's Name:_____
DOB:_____

SSN:_____
Employer:_____

Insurance Company Name & Address:
_____

Phone : _____ ID# :_____
Group # :_____

Secondary Insurance (if applicable):

Policy Holder's
Name:_____DOB:_____

SSN:_____Employer:_____

Insurance Company Name & Address:
_____

Phone:_____ ID# :_____

Group # :_____

Release of Information Form

Child's Name_____ Birth date_____

Guardian/s_____

Address_____City/State_____

Zip Code_____ Phone Number_____ Date_____

- I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, (Child's Name) _____ to Skillz 4 Life, Therapy. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Skillz 4 Life, Therapy to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

  Signed_____
  (Guardian)

- I hereby authorize Skillz 4 Life, 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 _____. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

  Signed_____
  (Guardian)

- I, _____, give my permission for Skillz 4 Life, Inc to photograph and/or videotape my child (Child's Name), _____, and use said photos/videos for promotional or teaching purposes.

  Signed_____
  (Guardian)

The release of information consent will expire in 1 year or after all billing issues related to this treatment will have been resolved. This consent may be revoked at any time through a written request to Skillz 4 Life, Therapy.

Individualized Needs Assessment

Child's name_____ Date of Birth_____ Name of person completing this form:_____
Relationship to child:_____
Is your child adopted? _____

Birth History
Child was born: ____ full-term or ____ premature; If premature, how many weeks?_____
Delivery: ____ vaginal ____ with forceps ____ C-section
Were there any complications?_____ Was your child placed in the Newborn Intensive Care Unit?____ If so, how long?_____ Please describe any other medical problems or complications at birth.
_____

Developmental History
Please indicate at what age your child achieved the following milestones: *Mark N/A for those which your child has not achieved yet

Rolled over_____
Sat alone_____
Crawled_____
Pulled to stand_____
Stood alone_____
Walked alone_____

Babbled_____
Said first word_____
Drank from a cup_____
Used spoon_____
Toilet trained_____
Dressed self_____

Current physical limitations:_____
Comments:_____

Medical History
Current diagnosis:_____
Hospitalizations: _____ No _____ Yes; If yes, please describe_____
_____
Surgeries: ____ No ____ Yes; If yes, please list_____
Previous psychological evaluation? ____No ____ Yes; If yes, please describe_____
_____
Current physician(s):_____
Medications:_____
Special equipment your child uses: Splints___Braces___Adaptive utensils____Other_____
Any feeding problems or nutritional concerns? _____

Please check all that apply to your child:

Trach ____ Allergies (list below) ____ Hearing aids ____ Wears glasses ____

C-Line ____ Latex sensitivity ____ Hearing difficulty ____ Vision problem ____ G-tube ____ Seizures ____

Comments: _____

Caregiver Concerns

What are your main concerns with your child?

_____

_____

What are your child's strengths?

_____

_____

Has your child received occupational therapy, music therapy, or speech therapy before? Y / N

If yes, please indicate which services and for how long: _____

_____

Educational Information

School/Educational program currently attending:_____ Present grade level:_____

Special services received in school:

_____MT _____ OT_____PT_____Speech

Does your child receive any of the following?

Special Education ____ Behavior Intervention ____ Other special service ____

Does your child's teacher have concerns with your child's development in any of the following areas?

Motor skills ____ Social abilities ____ Self-help skills ____ Learning abilities ____

Comments:_____

Social/Emotional Development

Does your child interact well with others? ____Yes ____ No

Does your child have any trouble making friends? ____ Yes ____ No

Fears, Coping behaviors:_____

Does your child have difficulty calming himself/herself when upset? ____ Yes ____ No

Additional comments:_____

Behavior

Please check any of the following that apply to your child:

Cries often	_____	Dislikes hair brushing	_____
Frequent temper tantrums	_____	Dislikes tooth brushing	_____
Anxious	_____	Avoids touch from others	_____
Trouble following directions	_____	Dislikes playground equipment	_____
Trouble with changes in routine	_____	Seems to be "on the go"	_____
Clumsy	_____	Rocks self	_____
Weak muscles	_____	Sensitive to light	_____
Picky eater	_____	Sensitive to sound	_____
Mouths objects	_____	Poor attention span	_____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

_____ _____

Signature Date

Patient Name _____

Emergency Medical Form

Child's Name_____

Allergies_____

Medical
Precautions_____

_____

Contact person in case of emergency_____

Relationship to Child_____

Phone Number_____

2nd Contact person_____

Relationship to Child_____

Phone Number_____

Our Policy is to call 911 in the case of any medical emergency. Please indicate if you would like us to do otherwise:

_____

_____

_____

Parent/Legal Guardian Printed Name_____

Parent/Legal Guardian Signature_____

Date_____

Patient Billing Acknowledgement Form Maintenance/Elective Care

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

Provider

Services to be provided are listed below:

Music Therapy, Occupational Therapy, and Speech Therapy including but not limited to all necessary services/supplies associated with therapy treatment.

Plan of care determined by therapist and family.

Provider Signature:

Patient

I, _____, acknowledge that I have been told in advance by my provider that the services/products listed above may or may not be covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature _____ Date _____

Patient Name

_____

HIPAA Release of information AUTHORIZATION FORM

I, _____hereby authorize Skillz 4 Life, Inc and its affiliates, its employees and agents , the ability to send me electronic communication containing my personal health information maintained (such as information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, Member ID number, payment arrangements and balance information) except the following information about me: _____ [DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of: helping me to resolve claims, or health benefit coverage issues, and the purpose of communication regarding plan of care.

I also allow the Skillz 4 Life, Inc staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of the child.

I understand that the electronic communication will be sent via an unsecure/unencrypted email network. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date listed below for one year.

I understand that I have a right to revoke this authorization by providing written notice to Skillz 4 Life, Therapy. However, this authorization may not be revoked if Skillz 4 Life, Therapy, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient (Print): _____

Name of Parent/ Guardian (Print): _____

Signature of Parent/ Guardian: _____ Date: _____

Notice of Privacy Practices and Confidentiality Agreement

**This Notice describes how health information about your child may be used and disclosed and how you can get access to this information.

The federal government has legislated the Health Information Portability and Accountability Act (HIPAA). The new rules regulate the privacy and accessibility of health information regarding your child's care at Skillz 4 Life, Inc. We must follow these privacy practices that are described in this notice until it is changed. Effective 4/14/03. You may request a copy of your notice at any time as applicable by law. Any changes added to this form will be available to you. You may request a copy of this at any time.

Use and Disclosure Information

Treatment-We may use or disclose your child's health information to plan a course of treatment that includes evaluation, goals and treatment approach. At times, your child's medical information may be reviewed by a student intern at our facility. In addition, your child's medical records will be provided to your health plan and consulting physicians. Your child may receive therapy services in the same room with another child. Within an Skillz 4 Life facility, your child's goals and data pertinent to your child's treatment may be discussed with others.

Payment-We may use and disclose your health information to obtain payment for services we provide to you/your family member. A bill may be sent to you or your health insurance payer. The information on the bill may obtain information that identifies you, your spouse or your child. This information may include the child's date of birth, diagnosis and procedures or supplies used.

Appointments-We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards or letters).

Check-In-Your child's name may be called when checking in at our window.

Schools and Agencies-We may provide information requested for IEP's, MFE's and evaluations with other professionals. We may disclose your child's information to doctors and other health professionals in regards to your child's care with us.

Other Permitted Uses and Disclosures

We may share information with other public health authorities charged with preventing or controlling disease, injury or disability. We will notify appropriate persons if we suspect child abuse or neglect.

We may need to provide medical information regarding your child to legal/judicial/administrative and law enforcement persons. We may need to send you information regarding your child's care or billing issues through the mail. We may also send you information about groups and programs. This information may come in a marked envelope with our address on it. We will not use or disclose your child's health information without your written authorization.

Confidentiality – No information regarding other patients may be shared outside the walls of Skillz 4 Life, Inc without parental permission.

Patient's Rights

- You have the right to view your child's health record and request a copy of it. There may be a copying and postage fee. You may be asked to show proof of guardianship or parent (driver's license, court order)
- You may request an amendment to your child's record. We are not required to make this change, but it will be noted in the record.
- You may restrict anything in our privacy act. We are not required to honor your request, but will make all efforts to accommodate reasonable requests. You may fax or mail this to us.
- Provide written authorization for uses and disclosures not otherwise permitted by law.

If you believe your privacy rights have been violated, you can file a complaint with our privacy officer or with the Secretary of Health and Human Services. Secretary-US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Signature:

I have read and understand/agree with Skillz 4 Life, Inc.'s Privacy and Policy Act.

_____ Date: _____

I have been given a copy of this for my records

_____ Date: _____

Patient Name _____

Attendance Policy

Scheduled Appointments:

- Please arrive for each appointment in time to check in and begin therapy at the scheduled time.
- A late fee of $15 may be assessed if you are 10 or more minutes late for your appointment.
- We recommend that you be involved in your child's treatment session. You are not required to stay in the treatment session, and may choose to wait in the designated waiting area.

Cancellations:

- If you must cancel an appointment due to an illness or emergency, contact our front office **24 hours** before the scheduled appointment or a $75 fee may be assessed. Our office staff will then ask for your availability to reschedule the appointment. If the appointment is not rescheduled within a rolling week then that missed appointment will count as a cancellation.
- When an appointment is rescheduled it is expected that your child will attend that appointment. Multiple cancels and reschedules require reviewing the child's schedule and determining if another time may be more beneficial.
- Please verify with us any appointments that will be canceled due to a vacation. We request to receive this information at least 14 days prior to the date which will be missed. We are unable to hold any time slot more than 2 consecutive weeks due to a vacation.
- In the event of inclement weather that may be a safety concern, contact our office if you are unable to make it to the appointment. A fee will not be assessed and a reschedule will be offered.
- Frequently canceled appointments (more than 2 canceled appointments of any discipline for every 8 scheduled) will be the basis for removal of your recurring appointment schedule. You will then be encouraged to schedule with more flexibility; scheduling on a week to week basis after each attended appointment.

No Shows:

- Failure to cancel or to appear during an appointment is considered as a no show. A $125 fee will be assessed. Please contact our office immediately to discuss future appointments.
- If we are unable to reach you within 3 days after a no show appointment, your child's appointment time will be automatically offered to another child waiting for services, and or your child may be terminated from the program.

A Note from the Therapists:

It is expected that families make every effort possible to attend scheduled appointments. When therapists establish a plan of care for your child, they base the goals and progress shared with the insurance company on the child having consistent therapy sessions (weekly). If your child misses appointments or arrives late, they will not meet their goals as quickly, and your child will likely need to be enrolled in therapy for a longer period of time. The success of treatment sessions depends on consistency and timeliness. In the event that a family does have to cancel, it is strongly encouraged that it be rescheduled, even if it is with another therapist. Skillz 4 Life, Inc appreciates it when another therapist provides care for one of their recurring patients. It gives the therapist new ideas and a different perspective to include in your child's treatment plan. Skillz 4 Life therapists are always in close communication with each other. Any other concerns regarding your child, please discuss this with your therapist.

I have read the attendance policy and understand the attendance expectations for my child.

_____

Parent/Guardian Signature Date

Patient Name _____