FUNCTIONAL KIDS THERAPY

every child deserves a champion

Outpatient Pediatric Intake Form

Child's Name: _____ Nickname:_____DOB: _____ Age: _____

M/F: _____ Current Diagnosis: _____

Address:_____ City:_____ State: ____ Zip Code: _____

Primary Phone: _____ Preferred E-mail: _____

Child's School: _____ Grade: _____

Parent #1 Name: _____ DOB:_____ Occupation: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

SS #:_____ Marital Status: M S W D (please circle one)

Parent #2 Name: _____ DOB:_____ Occupation: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

SS #:_____ Marital Status: M S W D (please circle one)

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Language: _____ Language(s) Spoken at Home: _____

Child's Primary Physician: _____ Address/Phone: _____

Child's Referring Physician: _____ Address/Phone: _____

Reason for Referral: _____

What are your primary areas of concern? What are you hoping for the therapist to address?

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

Please list any medical precautions, allergies, supplements and/or medications:

_____
_____
_____
_____

Is your child receiving any other services (i.e. counseling, ABA, special education, early intervention)?

_____
_____
_____
_____

What (if any) special equipment does your child use?

□ Wheelchair □ Eyeglasses □ Hearing Aids □ Orthotics □ Braces □ Walker □ Communication Device

□ Crutches □ Other: _____

Prenatal & Birth History:

Full-term	□ Yes □ No
Premature	□ Yes □ No If yes, how many weeks gestation? _____
Low birth weight	□ Yes □ No
Birth weight	____lb(s)____oz
Breech birth	□ Yes □ No
Type of delivery	□ C-section □ Vaginal If C-section, was it an emergency? □ Yes □ No
Forceps assisted	□ Yes □ No
Vacuum assisted	□ Yes □ No
Preeclampsia	□ Yes □ No
Gestational diabetes	□ Yes □ No
Multiple ultrasounds	□ Yes □ No
Oxygen deprivation	□ Yes □ No
NICU stay	□ Yes □ No If yes, what was the duration? _____

Please list any other significant prenatal or birth history:

_____
_____
_____
_____

Medical & Developmental History:

Jaundice	□ Yes □ No
Breast fed	□ Yes □ No
Formula fed	□ Yes □ No
Poor suction/latch	□ Yes □ No
Chronic ear infections	□ Yes □ No
Tubes	□ Yes □ No
Tonsils/adenoids surgery	□ Yes □ No
Acid reflux	□ Yes □ No
Poor weight gain	□ Yes □ No
Feeding problems/picky eating	□ Yes □ No
Tongue or lip tie	□ Yes □ No
Colic	□ Yes □ No
Sleeping problems	□ Yes □ No
Asthma	□ Yes □ No
Cardiac issues	□ Yes □ No
Frequent antibiotic use	□ Yes □ No
Frequent fevers	□ Yes □ No
Abnormal muscle tone	□ Yes □ No
Vision problems	□ Yes □ No
Compromised immune system	□ Yes □ No
Headaches	□ Yes □ No
Abnormal lab results	□ Yes □ No
Hearing problems/evaluation	□ Yes □ No
Allergies	□ Yes □ No
Wetting	□ Yes □ No If yes, day or night? _____

Please list any other significant medical history including significant illnesses, hospitalizations, or surgeries:

_____
_____
_____
_____

Check the statement that best describes your child:

□ Didn't like tummy time	OR	□ Loved being on belly
□ Met all motor milestones on time	OR	□ Was/is developmentally delayed
□ Is clumsy	OR	□ Has always seemed athletic
□ Struggles with use of hands/fine motor	OR	□ Uses utensils and pencils easily
□ Avoids climbing, swinging, being upside down	OR	□ Seems to crave/love movement

When did your child do the following?

Skill	***Age (months)***
Sat up	
Rolled over	
Pulled up to stand	
Belly crawled	
Hands and knees crawled	
Walked	
Spoke first word	
Spoke in sentences	

My child communicates using:

□ is non-verbal
□ single words
□ 2-3 word phrases
□ sentences

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.):

_____
_____
_____

Academic History:

Check all that applies to your child:

□ Does well in school
□ Does well with the exception of:_____
□ Is challenged by school
□ Is challenged by writing
□ Is challenged by reading comprehension
□ Is challenged by decoding
□ Receives intervention/tutoring for:_____
□ Has an IEP/IFSP
□ Is in a self-contained classroom

Describe your child's grades in school (Letter grades, areas of strength/weakness, etc.):

_____
_____

Please list any academic concerns you have:

_____
_____
_____
_____

Please list any concerns your child's teacher has mentioned:

_____
_____
_____

Behavior/Social History:

Check all that applies to your child:

□ Is social and engaging
□ Makes good eye contact with adults and peers
□ Is well behaved
□ Pays attention
□ Listens well
□ Follows directions well
□ Plays well with other children
□ Is easy going
□ Does well with change
□ Understands safety
□ Takes turns with peers
□ Is aggressive
□ Is oppositional
□ Does not like new places/people
□ Does not like crowds
□ Has difficulty with transitions
□ Prefers to play alone
□ Has difficulty paying attention
□ Has difficulty listening
□ Is very busy and active
□ Poor coping skills
□ Unable to self-calm
□ Extremely sensitive to criticism
□ Quickly escalates without apparent cause
□ Has tantrums

Please list any other behavioral, emotional, or social concerns:

_____
_____
_____

Evaluation & Therapy Services:

Please list any previous occupational, speech, or physical therapy evaluations completed and recommendations:

_____
_____
_____
_____

Please list any previous psychological/neuropsychological/psychoeducational evaluations completed and recommendations:

_____
_____
_____
_____

FUNctional Kids Parent/Guardian Conduct Policy

By signing below all guardians and parents are agreeing to adhere to the **FUNctional Kids** Conduct Policy which prohibits the use of any and all negative behaviors to intimidate, harass, belittle or threaten staff members in this place of business. Any violations with the above mentioned behaviors are grounds for immediate dismissal from therapy services. Be advised that any extreme situation experienced by a staff member can be immediately reported to the local authorities and your child's care will be immediately terminated from our practice without verbal or written advanced warning.

Parent /Guardian signature:_____Date: _____

FUNctional Kids Insurance Policy

You are responsible for knowing your benefits outlined in your specific insurance plan including your co-insurance, co-pay, and deductible amounts if applicable. Please be advised that many insurance providers do not cover therapy due to most developmental disorders. Functional Kids Therapy Center LLC is NOT responsible for these costs that are dictated by your insurance carrier and if coverage is denied you will be responsible for payment of care, including any evaluations.

Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, you are legally responsible for the amount outlined by your insurance carrier and will be sent to collections if the account goes unpaid. You are responsible for any finance charges & fees **Functional Kids Therapy Center LLC** incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on you account(s).

My signature below is confirmation that I have been informed of and agree to the insurance policy of **FUNctional Kids Therapy Center LLC.**

Insurance Information: *please list all active policies.*

Primary Insurance:_____
Subscriber: _____
Subscriber Date of Birth: _____
Relationship to client: _____
Contract/ID#: _____
Group #: _____
Employer: _____

Secondary Insurance: _____
Subscriber:_____
Subscriber Date of Birth:_____
Relationship to client: _____
Contract/ID#: _____
Group #: _____
Employer: _____

I, _____, hereby give my consent for FUNctional Kids Therapy Center LLC to bill my/my child's insurance carrier for the services rendered to me/my child/family by the above mentioned provider. In addition, I agree to pay FUNctional Kids Therapy Center LLC any remaining fees or uncovered charges in accordance with my health care plan.

_____ _____ _____
Parent/Guardian Signature | Relationship to client | Date

CONSENT FOR TELETHERAPY SESSION

Zoom is the technology service we will use to conduct teletherapy videoconferencing appointments. It is simple to use and there are passwords and a waiting room required to log in. By signing this document, I acknowledge:

- My therapist explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand there are clinical limitation to teletherapy such as lost attention and the therapist cannot perform hands on therapeutic physical intervention.
- I understand that my therapist or I can discontinue the teletherapy consult/visit if it appears that the videoconferencing connections are not adequate for the situation.
- I agree to mitigate transmission difficulties (e.g. moving in closer proximity to the wifi source) with my therapist up to three times within a session if wifi is disconnected.
- I understand my child's appropriateness for teletherapy is at the discretion of the therapist.
- I agree within this session my therapist will bill my insurance as a teletherapy treatment session. If my insurance does not cover the therapy session, I am responsible for the out of pocket costs of a private therapy session ($35.00 for half an hour, $75.00 for an hour session).
- I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this intervention. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

- Zoom is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
- Though my provider and I may be in direct, virtual contact through the Teletherapy Service, neither Zoom or my Functional Kids Therapy Center, LLC' therapist provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
- The Zoom Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
- I acknowledge I will be sent a private link, a password and will be admitted to a waiting room to access the treatment session and there will be no video recording for confidentiality purposes.
- I do not assume that my provider has access to any or all of the technical information in the Zoom Service – or that such information is current, accurate or up-to-date. I will not rely on my therapist/health care provider to have any of this information in the Zoom Service.
- To maintain confidentiality, I will not share my teletherapy appointment link with anyone unauthorized to attend the appointment.

By signing and giving verbal consent I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature:_____Date:_____

FUNctional Kids Attendance Policy

FUNctional Kids Therapy Center LLC wants to improve your child's quality of life through consistent and high quality care. Cancellations, especially those with less than 24 hour notice including no-call/no-shows limit your child's progress and our ability to care for others. Please call the Battle Creek location at (269) 223-7786 or the Caledonia location at (616) 536-2211 if you need to cancel or reschedule an appointment. We ask for your full cooperation with the following policy:

* If you are unable to keep your scheduled appointment, we request that you notify us immediately so that your appointment can be rescheduled and another patient may take your slot - there is an after hours answering machine for weekends. **You must cancel by noon the previous business day to avoid a $25 cancellation fee (not payable by insurance).**
* Greater than 50% cancellation in a 30 day period will also result in loss of preferred afternoon or early morning time slot(s) until further consistent attendance is established.
* **If you do not show up to a scheduled appointment, a $50 no-show fee will be added to your account and must be paid before resuming therapy (not payable by insurance).** All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
* If you accumulate two no-shows this will result in an automatic discharge and physician notification.
* If you are more than 15 minutes late for your appointment and you do not call the office you will be considered a no-show and will be charged $50 and dismissed from the practice.

We believe that this policy is necessary for the benefit of all patients, so that we can continue to provide high-quality treatment and service to everyone. If you should have any questions regarding this policy, please feel free to discuss them with your therapist.
My signature below is confirmation that I have been informed of and agree to the attendance policy of **FUNctional Kids Therapy Center LLC.**

Parent/guardian signature: _____ Date:_____

Notice of Video and Audio Recordings

Functional Kids Therapy Center prides itself on being a safe, inclusive environment for children and families of various backgrounds and needs. To ensure that we are maintaining a safe and inclusive environment, we have decided to add security features to our Battle Creek and Caledonia, Michigan locations, including video and audio recording devices. We have added these devices to main areas of the facilities, such as the waiting rooms and certain exist/ entry points. We value our patients' privacy and we can assure our patients that the recording devices are not located in any private bathrooms or examination rooms. We have posted notices around the facilities to notify our patients of these added security features. As the video and audio recording devices will record protected health information (PHI) and such PHI will be stored electronically (ePHI), please be assured that we have implemented and will utilize these security features in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the HIPAA Policies and Procedures of **Functional Kids Therapy Center, L.L.C.** We maintain appropriate administrative, technical and physical safeguards to ensure the confidentiality and integrity of any PHI and ePHI collected via any video and audio recordings and to protect against any breach or unauthorized use or disclosure of such information. We have also properly trained our workforce with respect to HIPAA rules and regulations as well as the use of these video and audio recording devices. **These devices are secure, closed circuit, password protected accounts that are NOT shared with the public.** We will only disclose video footage or audio recordings as requested by health care providers for treatment purposes, as expressly authorized by patients or as required by law.

By signing below, you acknowledge that **FUNctional Kids Therapy Center LLC** has implemented audio and video recordings on our premises and you authorize us to conduct such recordings.

Signature of Parent/Guardian:_____ Date: _____

Printed Name of Parent/Guardian: _____

Communication and Medical Information Authorization and General Release Form

I, _____ the parent/guardian of _____

(Parent's/guardian's name) (Child's name)

agree to allow **Functional Kids Therapy Center** to disclose the following health information regarding my child to/from the following providers or facilities as set forth below.

Section 1: HEALTH INFORMATION

☐ My child's complete health records including, but not limited to, examination, diagnoses, treatment, and billing records for all conditions

OR

☐ My child's complete health records, excluding any of the following information: (please specify below)

_____

_____

_____

Section 2: PERSONS WHO CAN RECEIVE MY HEALTH INFORMATION

I authorize **Functional Kids Therapy Center** to share my health information with the following persons:

	NAME	RELATIONSHIP	CONTACT
1.			
2.			
3.			
4.			
5.			

I understand that the persons listed above may not be covered by state/federal rules governing the privacy and security of data and may be permitted to further share my health information.

Section 3: DURATION OF AUTHORIZATION

This authorization to share my health information is valid:

☐ For all past, present, and future periods
☐ From _____ to _____
☐ From the date of signature until the occurrence of the following event:_____

I understand that I am permitted to revoke this authorization to share my health information at any time and I can do so by submitting a request in writing to the office manager at FUNctional Kids Therapy Center LLC.

However, in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health information.

Section 4: AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication (which may include a link to an online portal) to contact me as needed. I understand that my service provider may charge me for such communication and also that electronic communication, while very convenient, may not always be very secure.

I authorize to be contacted via text-message at _____
I authorize to be contacted via electronic mail at _____

☐ I prefer to be only contacted via US Mail and telephone number on file.

Section 5: GENERAL RELEASE

Regardless of any limitation set forth above, I understand and acknowledge that **Functional Kids Therapy Center** is permitted to make uses and disclosures of my health information for purposes of treatment, payment and health care operations.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits that I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

I understand that this information cannot be exchanged without my written consent and hereby give approval as outlines above.

Printed Name of Parent/guardian : _____

Signature of Parent/guardian: _____Date: _____

Consent Form

Photograph/Video Professional Services

I hereby give my consent for **Functional Kids Therapy Center** to use and disclose the professional images/video taken during therapeutic interactions with my child(ren) and the staff at Functional Kids Therapy Center LLC.

With this consent, **Functional Kids Therapy Center** may use these professional images and/or video for the creation of various promotional and marketing materials to promote other professional services to families and community members. This may include but is not limited to dissemination of materials to: other licensed health care professionals, teachers, parents, grandparents, chiropractors, physicians, nurses and any other allied health providers.

With this consent, **Functional Kids Therapy Center** may place this professional video/photo content on their website, Instagram or Facebook page. By signing below, I give Functional Kids permission to disclose what services that my child is receiving in the promotional materials and use their first name in the dialogue to better explain and promote the therapeutic services they are being shown to be participating.

By signing this form, I am consenting to allow **Functional Kids Therapy Center** to use and this imagery and understand that it will be used only for professional services to market and promote the services of the organization

Guardian/Parent Signature:_____Date: _____