777 Goguac St W Suite B-2 Springfield MI 49015

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OUTPAITENT 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

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. Ot/PT/SP, 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?
Low Birth Weight: □ Yes □ No _____ lb(s) _____oz	Breech Birth □ Yes □No
Type of delivery: □ Vaginal □ C-section □Emergency	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, duration?

Developments Milestones:

Sat up □ On time □ Delayed	Rolled over □ On time □ Delayed
Pulled to a stand □ On time □ Delayed	Belly crawled □ On time □ Delayed
Hands and knees crawled □ On time □ Delayed	Walked □ On time □ Delayed
Spoke first word □ On time □ Delayed	Spoke first sentence □ On time □ Delayed

Did your child experience prenatal exposure to alcohol, tobacco or drugs: □ Yes □No

Has your child's physical development been normal? □ Yes □No

If no please explain:

_____

_____

Has your child had any chronic health problems? (asthma, diabetes, heart condition, etc). □ Yes □No

If yes, please explain:

_____

_____

Are immunizations up to date: □Yes □No

Does this child have bladder control problems? At night □Yes □No If yes, how often? _____

During the day? □Yes □No If yes, how often? _____

Does this child have bowel control problems? At night □Yes □No If yes, how often? _____

During the day? □Yes □No If yes, how often? _____

My child communicates using:

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

Please list any other significant prenatal or birth history:

_____
_____
_____

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

_____
_____
_____

Has your child had any previous counseling, occupational, physical, and/or speech therapy services: ☐Yes ☐No

If yes please list:

_____
_____
_____

Medical History: Please rate your child in each of the following area:

	Good	Fair	Poor
Health	☐	☐	☐
Hearing	☐	☐	☐
Vision	☐	☐	☐
Gross Motor Coordination:	☐	☐	☐
Fine Motor Coordination:	☐	☐	☐
Speech Articulation:	☐	☐	☐

Past Treatment:

A) Has your child ever had any previous mental health treatment? ☐ Yes ☐ No

*If so please indicate which type and date/age at the time of treatment:

☐ Psychological Testing:	Age _____	Date _____
☐Individual/Group/Family Therapy:	Age _____	Date _____
☐ Psychiatric Hospitalization:	Age _____	Date _____
☐ Residential Treatment:	Age _____	Date _____

What was the Diagnosis?

_____
_____

B) Is your child currently on any medications? ☐ Yes ☐ No Reason: _____

*If so please list the medications:

Medication:_____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

** Have the above medication been effective? Please Explain:

_____

_____

_____

School History:

(check any of the following current school problems that apply)

☐ Oppositional ☐ Disrupt class ☐ Inattentive ☐ Refuse to go to school ☐ Disorganized

☐ Detention ☐ In-school suspension ☐ Out-of-school suspension ☐ Expelled from school ☐ Fail to turn in work regularly

Has your child ever had problems with his or their learning ability? ☐ Yes ☐ No

If yes please explain:

_____

_____

_____

_____

_____

_____

Summarize your child's progress (eg. Grades, Academics, Social Behavioral) within each of the following grade levels.

Preschool: _____

Kindergarten: _____

Grades 1-3: _____

Grades 4-6: _____

Middle School/JR High: _____

High School: _____

Have instructional modifications been attempted? ☐Yes ☐No

If yes please explain: _____

_____

_____

Has this child had any educational testing? ☐Yes ☐No

If yes please explain: _____

_____

_____

How does child get along with his/her sibling(s)?

☐ Better than average ☐ Average ☐ Worse than average ☐ Doesn't have any

How easily does this child make friends?

☐ Better than average ☐ Average ☐ Worse than average

About how many close friends does your child have?

☐ None ☐ 1-2 ☐ 3-5 ☐ 5 or more

On the average, how long does your child keep friends?

☐ Less than six months ☐ six months to a year ☐ 2 years+

Describe your child socially:

☐ Withdrawn ☐ Insecure ☐ Outgoing ☐ Passive ☐ Aggressive ☐ Other

What extra-curricular activities is your child involved in?

_____

_____

_____

What jobs or chores does your child have?

_____

_____

_____

Has your child ever had any legal problems: ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

Are you aware of any alcohol, tobacco and/or other drug use by your child? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

Religious/ Faith History

What is your family's religious background?

_____

_____

_____

Does your child currently attend church/synagogue, or mosque? ☐ Yes ☐ No If yes, where? _____

Please list any issues (positive or negative) that are important and may have affected your child in regard to faith:

_____

_____

_____

_____

Behavior/Social History (please check any concerns from the last six months)

☐ Excessive Crying

☐ Decreased Energy

☐ Feelings of being worthless

☐ Thoughts of suicide

☐ Felling overwhelmed

☐ Trouble making decisions

☐ Experience panic attacks

☐ Excessive worrying

☐ Avoiding going places

☐ Isolating from others

☐ Afraid of being judged/rejected

☐ Sensitive to criticism

☐ Needs things to be perfect

☐ Excessive anxiety about separation from caregivers

☐ Obsessive behaviors or thoughts

☐ Impulsive acts without thinking

☐ Can't sit still, antsy

☐ Always on the go, hyper

☐ Problems following the rules

☐ Difficulty with authority

☐ Unmotivated, procrastinating

☐ Trust issues

☐ Health concerns

☐ Concerns related to life change

☐ Memory problems

☐ Attention problems

☐ Apathetic, doesn't seem to care

☐ Abruptly changing moods

☐ Angry, easily irritated

☐ Difficulty controlling temper

☐ Reckless behaviors, taking excessive risks

☐ Abusive toward others

☐ Lying, stealing

☐ Avoid conflict

☐ History of traumatic experiences

☐ Full of energy, little need for sleep

☐ Feeling overly important

☐ Talking fast and excessively

☐ Hoarding food or objects

☐ Poor body image

☐ Problems with eating or food

☐ Stomach aches, digestion issues

☐ Trouble managing paid or disabling condition

☐ Aches and pains

☐ Financial concerns

☐ Legal problems

☐ Sexual concerns

☐ Feels bullied/picked on

☐ Few or no friends

☐ Considered "weird" by others

☐ Socially awkward or inappropriate

☐ Problems with boundaries

☐ Skin picking, hair pulling, nail biting

☐ Inflexible, trouble handling change

☐ Self-harm or cutting

☐ Problems in relationships with parents

☐ Problems with friends, siblings, roommates

☐ Problems in relationships with partner or children

☐ Difficulties with sleep

☐ Suspicious, paranoid

☐ Threatens or bullies' others

☐ thoughts of hurting others

☐ Gender identity issues

☐ LGBTQ

☐ Hearing or seeing things others do not

☐ Learning difficulties

☐ Abused or neglected by others

☐ Current (or past) excessive use of alcohol, drugs, or medications

Other: _____

_____

_____

_____

Family History

Check if there is any history of any of the following in the family. If yes, please let the family member (eg. Mother, grandfather, sibling etc.)

☐ Learning Disabilities _____ ☐ ADD/ADHD _____ ☐ Mental Retardation _____

☐ Depression _____ ☐ Anxiety Disorder _____ ☐ Tics or Tourettes _____

☐ Psychosis or Schizophrenia _____ ☐ Arrests _____ ☐ Alcohol or Durg Abuse _____

☐ Birth Defects _____ ☐ Diabetes _____ ☐ Suicide Attempts/Suicide _____

☐ Bipolar Disorder (Manic Depression) _____

Living Situation

Who has legal custody of your child? _____

☐ Both parent's home ☐ Relative's home ☐ One parent's home

☐ Friends home ☐ Legal guardian's home ☐ Other

Primary living situation for the past year:

☐ Both parent's home ☐ Relative's home ☐ One parent's home

☐ Friends home ☐ Legal guardian's home ☐ Other

Please describe the family home: ☐ House ☐ Apartment ☐ Condo ☐ Trailer (mobile home/RV camper)

Please indicate who sleeps in each room:

_____

_____

_____

Please describe your neighborhood:

_____

_____

_____

Who has taken care of the child most of their life? _____

_____

Who is the primary disciplinarian in the family? _____

Are they: ☐ Strict ☐ Lenient

Do the parents usually agree on the issues of parenting, rules and discipline?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

Do the parents get along with each other?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

What strategies have been used to address problems? (check those that apply and circle those that have been successful)

□ Verbal Reprimands □ Time out □ Removal of privileges □ Rewards

□ Physical Punishments □ Giving in to the child □ Avoiding the Child □ Other

On the average, what percentage of the time does your child comply with initial commands?

□ 0-20% □ 20-40% □ 50% □ 60-80% □ 80-100%

On the average, what percentage of the time does your child eventually comply with commands?

□ 0-20% □ 20-40% □ 50% □ 60-80% □ 80-100%

Have there been any major stressors or changes in the family home where the child was raised? □ Yes □ No

If yes, check all that apply:

	Past	Current (6 months or less)		Past	Current (6 months or less)
Financial problems	_____	_____	Separation from Sibling(s)	_____	_____
Frequent Moves	_____	_____	Mental Illness in Family	_____	_____
Job Changes	_____	_____	Physical Illness in Family	_____	_____
Drinking/Drug Problems	_____	_____	Psychiatric Hospitalization of Parent	_____	_____
Arguments between Parents	_____	_____	Death in the Family	_____	_____
Separation between Parents	_____	_____	Incestuous Behavior in Family	_____	_____
Remarriage of Parent(s)	_____	_____	Other	_____	_____

What are the family's strengths? _____

_____

_____

What are the family's weakness'? _____

_____

_____

What are the child's strengths? _____

_____

_____

What are the child's weakness's? _____

_____

_____

What do you see as an issue(s) important to the child: _____

_____

_____

Please mark statements below that apply to your family:

Our family is warm and loving	□ Yes	□ No
People are often arguing	□ Yes	□ No
Everyone goes his/her own separate way	□ Yes	□ No
People say what is on their minds	□ Yes	□ No
Our family hides things	□ Yes	□ No

What would you change about your family?

_____
_____
_____

How has the family been changed by the child's problem?

_____
_____
_____

What is the family's expectation of treatment?

_____
_____
_____

What does the family see as their role in treatment? Which family members are willing and able to participate?

_____
_____
_____

Please list any disabilities or disorders that your child has that have not been previously mentioned:

_____
_____
_____

Describe your child's adjustment to these disabilities and/or disorders:

_____
_____
_____

Is there a need for assistive technology in the treatment of this child? ☐ Yes ☐ No

If yes please explain: _____

_____

Is there anything else about this child or family that we should know in order to be more helpful? _____

_____

_____

_____

*** please bring this form, as well as psychological or educational test results, report cards, behavior modification charts and any other pertinent documents to your next appointment.*

_____ _____

Parent/Guardian Signature Date

Read and reviewed by _____ _____

Clinician Date

FUNCTIONAL KIDS THERAPY
every child deserves a champion
Phone: (269) 223-7786 Fax: 269-962-9569
777 Goguac Street W Suite B2 Springfield MI 49015

Patient Information and Consent to Treatment

Thank you for choosing Functional Kids Therapy for your counseling needs. We are committed to giving you the best care possible. To familiarize you with the policies and procedures of our clinic, we are providing the following information.

Appointments: If you need to cancel an appointment, you must call by noon the day before; otherwise you are subject to a $25 cancellation fee. If you no-show for your appointment you will be subject to a $50 fee. No-show and cancellation fees are not payable by the insurance company and are the responsibility of the parents/legal guardian. If canceling after business hours, please leave a message on the office voicemail with a date, time, and reason for your cancellation. Our LPC will do their best to be punctual responding to your messages and for your visits. We ask that you be punctual as well. If you are late, for any reason, you will receive the remainder of your scheduled time. This is necessary to provide excellent care to all of our patients.

Emergencies: In case of an AFTER-HOURS emergency, go to the nearest emergency room. Functional Kids Therapy does not have an emergency number.

Financial Responsibility: Complete the financial policy attached. We accept cash, check, money orders, credit/debit cards (Visa, Mastercard, Discover – 3% convenience fee), and HSA cards for your convenience. There will be a $25 NSF fee for payments returned as non-sufficient funds or non-payable. All services rendered will be billed to your or your contracted insurance plan. You are fully responsible for all services rendered. If you have any questions regarding you billing please call (269) 339-3380 to speak with our billing department.

Confidentiality: Your patient records are the property of Functional Kids Therapy LLC and shall be treated as confidential, to insure quality record maintenance and patient confidentiality. Functional Kids Therapy LLC will conduct routine patient record audits. To comply with state and federal laws regarding confidentiality your records will not be released without written consent. Everything about your care will be held in the strictest confidence (with the exception of situations which we are required by law to report: such as suspected or reported child abuse, etc.). If you choose to have your Functional Kids Therapy LLC providers(s) keep a third party informed of your progress in counseling, it will be necessary to complete a "Release of Information" form that will be kept on file.

Non-Voluntary Discharge from Treatment: A patient may be terminated from Functional Kids Therapy LLC non-voluntarily, if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment/ payment arrangements in a timely manner. The patient will be notified of the non-voluntary discharge by letter. The patient may appeal this decision with the Functional Kids Therapy Clinic Director or request to reapply for services at a later date.

Please sign below to indicate you have read and understand the above notifications and that you are consenting to receive treatment by a Functional Kids Therapy LLC provider.

_____	_____	_____
Client/Authorized Person Signature	*Relationship*	*Date*

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: _____

Client Agreement and Acknowledgements

Privacy Policy: I acknowledge having been offered Functional Kids Therapy LLC "Notice of Privacy Policies" and their "Clients Rights Statement" (_____)please initial

Consent for treatment: I hereby consent to the treatment provided by Functional Kids Therapy LLC and the employees or designees. I authorized services deemed necessary or advisable by my caregivers to address my needs. (_____) please initial

_____ _____ _____

Client/Authorized Person Signature *Relationship* *Date*

Child and Adolescent Consent for Treatment

Child's Name _____ DOB _____

Certify that I am the *father mother legal guardian* (circle one) of the above child/adolescent and that I do have legal custody of _____. I, hereby, give my authorization and consent for the above named child/adolescent to receive outpatient assessment/therapy from Functional Kids Therapy LLC.

_____ _____ _____

Client/Authorized Person Signature *Relationship* *Date*

Divorce/Legal Separation Collection Policy

It is the policy of **FUNctional Kids Therapy LLC** that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child/adolescent's treatment regardless of any financial arrangement for payment for medical care, either oral or written, with the child/adolescent's other parent or responsible party. **FUNctional Kids Therapy LLC** assumes NO responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child/adolescent's medical care.

I have read, understand and agree to the above policy.

_____ _____ _____

Client/Authorized Person Signature *Relationship* *Date*

_____ _____

Witness 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:

Primary Insurance: _____

Subscriber:_____

Subscriber date of birth: _____

Relationship:_____

Contract/ID#_____

Group#_____

Employer: _____

Secondary Insurance :_____

Subscriber: _____

Subscriber date of birth: _____

Relationship: _____

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** deductibles or uncovered charges in accordance with my health care plan.

_____ _____ _____

Parent/Guardian Signature *Relationship to client* *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: _____