Notice and Acknowledgement

Acknowledgment:

I acknowledge that I have read the Notice of Privacy Practices as displayed on the Kids In Motion web site.

____________________________________ _________________________

Patient or Personal Representative Signature | Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

AUTHORIZATION FOR TREATMENT
AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE KIDS IN MOTION TO TREAT MY CHILD OR MYSELF. I FURTHER HEREBY AUTHORIZE KIDS IN MOTION TO RELEASE MINE OR MY CHILD'S RECORDS TO MY INSURANCE COMPANY OR THIRD PARTY PAYER WHEN NECESSARY FOR PAYMENT OF MY BENEFITS. I ADDITIONALLY AUTHORIZE MINE OR MY CHILD'S RECORDS TO BE RELEASED TO MY REFERRING PHYSICIAN OR OTHER TREATING PHYSICIANS. I AUTHORIZE MINE OR MY CHILD'S MEDICAL RECORDS TO BE RELEASED TO THE PROPER MEDICAL PERSONNEL IN CASE OF AN EMERGENCY.

I HEREBY AUTHORIZE REIMBURSEMENT DIRECTLY TO KIDS IN MOTION. I ALSO AGREE THAT IF THE INSURANCE COMPANY ISSUES PAYMENT DIRECTLY TO ME FOR THESE SERVICES, I WILL PAY THE AMOUNT ISSUED BY MY INSURANCE COMPANY TO KIDS IN MOTION WITHIN 15 DAYS OF RECEIVING PAYMENT.

I HEREBY AUTHORIZE KIDS IN MOTION THERAPISTS TO CONSULT WITH OTHER THERAPISTS OR DOCTORS OF THE PATIENT.

I CAN NOT HIRE KIDS IN MOTION PEDIATRIC THERAPY SERVICES' THERAPISTS DIRECTLY.

IF AT ANYTIME YOU HAVE A CHANGE OF INSURANCE COMPANIES, CONTACT US IMMEDIATELY. WE MAY NOT TAKE YOUR NEW INSURANCE COMPANY AND IN ORDER TO USE ANY SECONDARY INSURANCE YOU MUST ABIDE BY THE RULES OF YOUR PRIMARY INSURANCE COMPANY OR YOU WILL BE RESPONSIBLE FOR THE BILL.

A PARENT OR CARETAKER MUST REMAIN IN THE HOME DURING THERAPY. NOT ONLY IS THIS SAFER IN CASE OF AN EMERGENCY, BUT THIS IS ALSO A TIME TO LEARN YOUR CHILD'S HOME PROGRAM.
ALL PATIENTS: CO PAYS, CO INSURANCE AND DEDUCTIBLES ARE COLLECTED AT TIME OF VISIT. HOME CARE PATIENTS NEED TO SET-UP A CREDIT CARD ON FILE FOR THESE CHARGES.

I GIVE MY PERMISSION TO KIDS IN MOTION PEDIATRIC THERAPY SERVICES INC. TO PHOTOGRAPH AND/OR VIDEO MYSELF OR MY CHILD OR CHILDERN FOR EVALUATION AND MARKETING PURPOSE. THIS MAY INCLUDE PICTURES IN A BROCHURE, NEWSPAPER, AND/ OR WEB SITE. ALSO IT COULD INCLUDE PHOTOGRAPHING TO SHOW PROGRESS AND REVIEWS FOR HOME PROGRAMMING. I GIVE MY PERMISSION TO KIDS IN MOTION PEDIATRIC THERAPY SERVICES INC. TO HAVE MY CHILD'S THERAPY SESSION ATTENDED BY DOCTORS AND/ OR STUDENT THERAPISTS FOR TEACHING EXPERIENCES.

☐ I DO NOT GIVE PERMISSION TO PHOTOGRAPH

SIGNATURE__________________________ RELATIONSHIP TO PATIENT____________________________

DATE _________________________________PATIENT NAME ____________________________________

⬧Cancellations and No-Show Policy

- The following are our policies regarding cancellation and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually the referring doctor and/or the therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is the most important job. If the therapist instructions are followed at home, then goals will be achieved faster.

- We require 24 hours notice in the event of a cancellation. It is the patient's responsibility, when he or she calls in, to have an alternative time in mind that will ensure they get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two consecutive days.). There is a $50.00 charge for a cancellation without proper notice. We understand the occasional ill child, but not "I forgot." or "Company showed up". Three no shows could result in your child being discharged from therapy. This charge will not be covered by insurance, but will have to be paid by the patient personally.

- The patient may need to see a therapist other than the one who normally treats them if we do rearrange the appointment. All of our therapists are experienced professionals. They will study the patient chart and ensure the patient is in knowledgeable and good hands. The patient will return to his/her original therapist in the next regularly scheduled visit.

- When a patient doesn't show as scheduled, three people are hurt: The patient himself or herself because they don't get the treatment they need as prescribed by the doctor and /or therapist, the therapist who now has a space in their schedule since the time was reserved for that patient personally, and another patient who could have been scheduled for treatment if there had been proper notice.

- The staff may exercise discretion in certain circumstances on a first "no-show" or improper cancellation. If a patient who is normally punctual has some unforeseen problem, they may choose to overlook it the first time. However, a second such instance will be billed, and after a third and fourth such instance, we have to question the patient's commitment to the program. Barring actual problems in treatment, which should be checked for, such uncommitted patients will be returned to their referring physician with an explanation as to why we have not been able to obtain compliance.

- Excessive tardiness is also grounds for discharge.

I have read and understand this policy.

______________________________	______________________________
Patient's name	Parent or Guardian's signature

Date:______________________________

PATIENT RIGHTS AND RESPONSIBILITIES

RESPONSIBILITIES:

1. As a patient of Kids In Motion Pediatric Therapy Services you have a right to be informed of your rights and responsibilities.
2. You also are responsible for understanding the provisions of your health care coverage, including deductibles, co-pays, limitations, and referral or authorization requirements.
3. All patients: co-pays, co-insurance and deductibles are collected at the time of visit.
4. Charges accrued after My Insurance Company or Agency has paid, Kids in Motion will Invoice me. I understand Payment is due within 14 days. I understand that if not paid within 14 days that 7% annually will be added to balance monthly of non-payment.
5. You are responsible for keeping your appointments & for telling your health care provider if you cannot keep an appointment.
6. Each therapy session will last thirty minutes to 53 minutes, if tolerated. Please write down your appointment times. **Not being at the clinic for a scheduled time will result in a $50.00 charge to your family if 24-hour notice is not given.** Three no shows could result in your child being discharged from therapy. Excessive cancellations or tardiness by patient/family could result in the patient being discharged from therapy.

RIGHTS

1. The right to be informed in advance of admission to Kids In Motion Pediatric Therapy Services:
   -Orally and written of your rights and responsibilities.
   -Informed of care and treatment to be provided.
   -Informed of changes in care plan that may affect your well being.
   -Informed of items and services that will be billed to your insurance.
   -Informed of non-covered services that you may have to pay, if known.

2. The right to be treated with courtesy, dignity, and respect and to treat others with respect.
3. The right to accept or decline services at any time and to be informed of the health consequences.
4. The right to decline or accept to be a participant in research, experimental or educational training without punitive action being taken against you.
5. The right to receive an explanation of forms you are asked to sign.
6. The right to participate in planning care & treatment of yourself or dependant unless judged incompetent.
7. The right to confidentiality of clinical records and communication between you and staff.
8. The right to access patient records by patient or legal guardian with staff supervisor onsite.

My signature acknowledges that I have been informed of my rights as a patient.

Signature____

Date

Patient Name ____

Relationship to Patient____

Patient Registration Form

First Name ______________ MI ___ Last Name ______________

Alias ______________

Gender: ☐ Male ☐ Female

Mailing Address ______________
____

Date of Birth ______________
Social Security # ______________
Driver's Lic # ______________

Physical Address ______________
____
____

		OK To Call	Best Time To Call
Home Phone	______________	☐	______________
Work Phone	______________	☐	______________
Cell Phone	______________	☐	______________

Marital Status: ☐ Divorced ☐ Separated ☐ Married ☐ Single ☐ Unknown ☐ Widowed

Employment Status: ☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Student Status: ☐ Full-Time ☐ None ☐ Part-Time

Email Address ______________

Parent 1 ______________
____
____

Parenting Status: ☐ Natural ☐ Foster ☐ Adoptive ☐ Other:______________ ☐ Preferred Contact ☐ Patient lives with this parent

		OK To Call	Best Time To Call
Home Phone	______________	☐	______________
Work Phone	______________	☐	______________
Cell Phone	______________	☐	______________

Parent 2 ______________
____
____

Parenting Status: ☐ Natural ☐ Foster ☐ Adoptive ☐ Other:______________ ☐ Preferred Contact ☐ Patient lives with this parent

		OK To Call	Best Time To Call
Home Phone	______________	☐	______________
Work Phone	______________	☐	______________
Cell Phone	______________	☐	______________

Legal Guardian (if not parent) ______________
____
____

		OK To Call	Best Time To Call
Home Phone	______________	☐	______________
Work Phone	______________	☐	______________
Cell Phone	______________	☐	______________

Emergency Contact ______________
____
____

		OK To Call	Best Time To Call
Home Phone	______________	☐	______________
Work Phone	______________	☐	______________
Cell Phone	______________	☐	______________

Primary Physician: ______________________

Org Name ______________________

Address: ______________________

City/State/Zip: ______________________

Phone: ______________________

Fax: ______________________

Referring Physician/Clinician: ______________________

Org Name ______________________

Address: ______________________

City/State/Zip: ______________________

Phone: ______________________

Fax: ______________________

Primary Insurance:

Primary Insurance (attach a copy of the front and back of your insurance card):

Ins Company: ______________________ Effective Date: ____________

Injured/Subscriber Information:

☐ Self ☐ Spouse ☐ Child ☐ Other: ____________

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone ______________________

Guarantor DOB: ____________

Contact/Case Manager: ______________________

Is a referral/authorization required? ☐ Yes ☐ No

Deductible: ____________ Copay: ____________

ID # ____________ Group #: ____________

Injured/Subscriber Employer:

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone ______________________

Sex: ☐ Male ☐ Female

Phone ______________________

Secondary Insurance:

Secondary Insurance (attach a copy of the front and back of your insurance card):

Ins Company: ______________________ Effective Date: ____________

Injured/Subscriber Information:

☐ Self ☐ Spouse ☐ Child ☐ Other: ____________

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone ______________________

Guarantor DOB: ____________

Contact/Case Manager: ______________________

Is a referral/authorization required? ☐ Yes ☐ No

Deductible: ____________ Copay: ____________

ID # ____________ Group #: ____________

Injured/Subscriber Employer:

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone ______________________

Sex: ☐ Male ☐ Female

Phone ______________________

Tertiary Insurance

Tertiary Insurance (attach a copy of the front and back of your insurance card):

Ins Company: ______________________ Effective Date: ____________

Injured/Subscriber Information:

☐ Self ☐ Spouse ☐ Child ☐ Other: ____________

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone ______________________

Guarantor DOB: ____________

Contact/Case Manager: ______________________

Is a referral/authorization required? ☐ Yes ☐ No

Deductible: ____________ Copay: ____________

ID # ____________ Group #: ____________

Injured/Subscriber Employer:

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone ______________________

Sex: ☐ Male ☐ Female

Phone ______________________

Patient Responsibility

Name ______________________

Address ______________________

City/State/Zip ______________________

Sex: ☐ Male ☐ Female

DOB ____________

Additional Information

Providing this information is optional but is essential in helping us apply for grants to fund our services for families who cannot afford it. This information is confidential and will not be disclosed on an individual basis but will only be used to provide consolidated information to organizations that can provide funding for our services.

Ethnicity:

☐ White, non-Hispanic ☐ Asian/Pacific Islander

☐ Black, non-Hispanic ☐ American Indian/Alaskan Native

☐ Hispanic ☐ Other: ______________________

Do you speak English? ☐ Yes ☐ No

Do you understand English? ☐ Yes ☐ No

Do you require an interpretor? ☐ Yes ☐ No

If so, what language? ______________________

School District where patient attends? ______________________

Household Income:

☐ Less than $10,000 ☐ $40,000-$50,000 ☐ $80,000-$90,000

☐ $10,000-$20,000 ☐ $50,000-$60,000 ☐ $90,000-$100,000

☐ $20,000-$30,000 ☐ $60,000-$70,000 ☐ Over $100,000

☐ $30,000-$40,000 ☐ $70,000-$80,000

☐ If I was paying out-of-pocket for my visit(s), the regular rate of $200/visit would be a financial hardship for me or my family

Number of People in Household: __________

Female Head of Household: ☐ Yes ☐ No

☐ **I have received a Fee Schedule**

Services To Be Provided:

Type of Service Requested:

☐ Physical Therapy ☐ Speech/Language Therapy ☐ Massage Therapy

☐ Occupational Therapy ☐ Music Therapy ☐ Other ______________________

Reason for Initial Visit? ______________________

____

Are you requesting services for injuries resulting from an accident?

☐ Work ☐ Auto ☐ Other ☐ None

How did you hear about us?

☐ Physician ☐ Hospital ☐ Marketing Ad - Print

☐ Employer ☐ Cross Referral ☐ Marketing Ad - TV

☐ Case Manager ☐ Friend - Word of Mouth ☐ Marketing Ad - Billboard

☐ Former Patient ☐ Attorney ☐ Marketing Ad - Direct Mail - Email

☐ Adjustor ☐ Self

☐ School ☐ Screens - Open Houses

Specify: ______________________

PAYMENT VERIFICATION SHEET (EFFECTIVE 2009)

PAYMENTS ARE DUE AT THE TIME SERVICE IS RENDERED.
(Including home and alternate clinic services)

Patient Name: ______________________________

TO HAVE A CREDIT CARD ON FILE, PLEASE FILL OUT THE FOLLOWING: (Required for offsite visits)

Please bill my Visa ____ Master Card ____ Discover _____

Per visit ____ Monthly (estimated ahead) ______ (If you prefer to pay monthly, this needs to be paid in advance NOT after services were performed. If you miss a visit, it will show as a credit on your account.

Name as appears on card: _____________________________________

Card number: _________________________

Expiration date: ___________

Address of credit card holder: ____________________

Zip code of credit card holder: _________

Signature: ________________________ Date: _______________

Medical History

Patient Name: ______________________________

Pregnancy / Delivery

Pregnancy Proceeded ☐ With Complications

- ☐ Eclampsia
- ☐ Gestational Diabetes
- ☐ Multiple Births
- ☐ Positive for Cytomegalovirus 'CMV'
- ☐ Positive for Herpes
- ☐ Positive for HIV
- ☐ Positive for Strep B
- ☐ Pre-eclamsia
- ☐ Premature Labor
- ☐ Substance Exposure
- ☐ Toxemia
- ☐ Other ______________________________

☐ Without Complications

Length of Pregnancy (in weeks) ____________________ Prenatal care was ☐ Received ☐ Not Received

Mothers age at time of birth __________ Birth Hospital ______________________________

Needed to be transfered to another hospital ☐ Yes ☐ No Transfer Hospital ______________________________

Delivery Proceeded ☐ With Complications

- ☐ Abruptio Placenta
- ☐ Breech Presentation
- ☐ Negative Vacuum
- ☐ Placenta Previa
- ☐ Premature Rupture of Membranes
- ☐ Prolapsed Cord
- ☐ Transverse Presentation
- ☐ Umbilical Cord Wrapped Around Neck
- ☐ Use of Forceps
- ☐ Uterine Rupture
- ☐ Other ______________________________

☐ Without Complications

Deliver was ☐ Vaginal ☐ C-section ☐ Emergency C-section Days in Hospital ____________

Birth Weight __________ Birth Height __________ Apgar 1 min ______ 5 min ______ 10 min ______

Comments

Following Birth

Complications Following Birth

- ☐ Anemia of Prematurity
- ☐ Brohopulminary Dyspasia 'BPD'
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus
- ☐ ECMO
- ☐ Faiture to Thrive
- ☐ Hyperbilirubinemia
- ☐ Intrauterine Growth Retardation 'IUGR'
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV Maconium
- ☐ Aspiration Necrotizing
- ☐ Enterocolitis 'NEC' Neonatal
- ☐ hypoxia
- ☐ Oxygen dependency
- ☐ PDA
- ☐ Positive dependency
- ☐ Respiratory Distrress Syndrome
- ☐ Respiratory Stridor
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Ventilator Dependency
- ☐ VP Shunt

Diagnosed or Suspected Syndromes

Health Issues

- ☐ Anoxic Brain Injury
- ☐ Arteriovenous Malformation 'AVM'
- ☐ Asthma / Respiratory
- ☐ Cerebral Vascular Accident 'CVA'
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Consitpation / Diarrhea
- ☐ Reflux
- ☐ Seizure Disorder
- ☐ Sleep Problems
- ☐ Traumatic Brain Injury 'TBI'
- ☐ Tube Feedng

Allergies

Current Medications

Current Vitamins, Herbs, Minerals, Homeopathics

Hearing Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Test Date ______________

Results

Concerns

Vision Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Test Date ______________

Results

Concerns

Specialists Seen		
Specialist	**Name**	**Reason**
Allergist		
Audiologist		
Cardiologist		
Developmental Medicine		
Endocrinologist		
ENT		
Gastroenterologist		
General Surgeon		
Geneticist		
Hand Surgeon		
Internal Medicine		
Nephrologist		
Neuro-Surgeon		
Neurologist		
OBGYN		
Oncologist		
Opthamologist		
Orthopedic Surgeon		
Pediatrician		
Physiatrist		
Podiatrist		
Psychiatrist		
Rheumatologist		
Thoracic Surgeon		
Urologist		

Diagnostic Tests		
Test	**When**	**Results**
ABR/ BAER		
Blood Work / Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Upper Endoscopy		
X-Ray		

Surgeries and Procedures			
Type	**When**	**Age**	**Results**

Contraindications / Precautions

- ☐ Allergies
- ☐ Baclofen Pump
- ☐ Braces
- ☐ Osteoporosis
- ☐ Seizure Condition
- ☐ Shunts
- ☐ Tube Feeding
- ☐ Vagal Nerve Stimulator
- ☐ None

Medical Conditions

Orthopedic Conditions

Developmental History

Motor / Sensory / Plan			
Milestone	**When (in months)**	**Milestone**	**When (in months)**
Creeps / Crawls Alone		Rolls Over	
Grabs Toys		Sits Alone Without Support	
Holds Head Up Alone		Walks Unaided	
Pulls Self to Standing Position			

How does child get around the house?

Favorite Toys / Play Activities

☐ Yes ☐ No Does child fall or lose balance easily? Is your child ☐ Right ☐ Left ☐ Neither

☐ Yes ☐ No Child visually looks at people and/or toys?

☐ Yes ☐ No Child show a negative response when touched or when touching other objects?

☐ Yes ☐ No Child enjoy movement such as swinging or roughhousing?

☐ Yes ☐ No Child play and/or participate in leisure activities daily?

☐ Yes ☐ No Child involved in community programs (school, special rec., scouts, etc.)?

Feeding / Speech / Language

Describe Any Feeding Problems

Food Likes

Food Dislikes

Feeding / Speech / Language			
Milestone	**When (in months)**	**Milestone**	**When (in months)**
Begin Eating Baby Food		Name Familiar Objects	
Begin Eating Junior Food		Using a Bottle	
Begin Eating Table Food		Using A Pacifier	
Begin Using A Cup, Sippy Cup, Straw		Use Two-Word Combinations	
Complete Sentences			

Areas of Difficulty

- ☐ Chewing
- ☐ Drooling
- ☐ Transitioning Between Foods
- ☐ Communication Needs
- ☐ Swallowing
- ☐ Understanding Words

Primary Communication

- ☐ Non-Verbal
  - ☐ Body Language
  - ☐ Manual Sign Language
  - ☐ Eye Gaze
  - ☐ Pointing / Gesturing
  - ☐ Facial Expressions
- ☐ Verbal
  - ☐ Phrases
  - ☐ Single Words
  - ☐ Sentences
  - ☐ Vocalizations

Augmentative Communication Device ______________________________

First Words ______________________________

☐ Yes ☐ No Do most people understand your child's speech?

☐ Yes ☐ No Does your child understand instructions?

Description of Child

- ☐ Active
- ☐ Curious
- ☐ Fearless
- ☐ Persistent
- ☐ Affectionate
- ☐ Demanding
- ☐ Fussy
- ☐ Playful
- ☐ Aggressive
- ☐ Difficult to Comfort
- ☐ Insecure
- ☐ Shy
- ☐ Calm
- ☐ Distractible
- ☐ Motivated
- ☐ Stubborn
- ☐ Cautious
- ☐ Fearful
- ☐ Passive
- ☐ Withdrawn

Primary Communication

Grade in School ____________ Name of School ______________________________

☐ Yes ☐ No Does your child have an IEP from school?

☐ Yes ☐ No Has your child had a psychological or neuropsychological evaluation completed?

Therapy Services	**Name of other Therapist**	**Email**	**Frequency/Duration**
Assistive Technology			
Audiology			
Behavior Therapy			
Nutrition			
Occupational Therapy			
Physical Therapy			
Social Therapy			
Speech / Language Therapy			
Vision Therapy			