Date: _____

Patient Name: _____

Nickname: _____Gender: F ☐ M ☐ Date of Birth: _____ Age: _____

Is child adopted? _____ Person to contact: _____

Diagnosis: _____

Allergies: _____ Medications: _____

Child's Physician: _____ Physician's Phone Number: _____

Referred by: _____ Reason for Referral: _____

How did you hear about us? _____

Parent/Guardian's Name (1): _____

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

Occupation: _____ Cell: _____ Work: _____

Phone Carrier: _____ Email: _____

Parent/Guardian's Name (2): _____

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

Occupation: _____ Cell: _____ Work: _____

Phone Carrier: _____ Email: _____

Sibling(s) – With whom does your child live?

Name	Age	Sex	Grade	Special Needs
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PERSON RESPONSIBLE FOR BILLING – <u>TRICARE FAMILIES ONLY</u>

Name of Sponsor: _____ Sponsor's DOB: _____

Sponsor's SSN: _____ Active: _____ Retired: _____

Patients relationship to insured: ○ child ○ self ○ spouse ○ other

Contact Cell: _____ Phone Carrier: _____

Email: _____

PERSON RESPONSIBLE FOR BILLING – <u>COMMERCIAL INSURANCE FAMILIES ONLY</u>

Name of Insurance Holder: _____ Insurance Holder's DOB: _____

Patients relationship to insured: ○ child ○ self ○ spouse ○ other

Contact Cell: _____ Phone Carrier: _____

Email: _____

PAYMENT AGREEMENT FORM

Patient's Name: _____ Patient's DOB: _____

Parent/Guardian's Name: _____

Insurance Company: _____

Amount due at time of service: $ _____ (PER VISIT) / (PER DISCIPLINE)

Please understand that your insurance may require you to pay a copay or patient responsibility amount for each treatment that your child receives. Per the insurance contract, we must collect the amount due on the date of service.

As a courtesy, TLC Kids Therapy verifies your benefits with your insurance company. A quote of these benefits, based on information provided from the insurer, is not a guarantee of benefits or payment. Your claim will process according to your insurance plan; if your claim processes differently from the benefits originally quoted, we will review the insurance claim and charge you the correct amount your insurance plan requires. Unfortunately, this means we may not be able to honor the original quote of benefits received if the payout from insurance differs from that original quote.

It is our policy at TLC Kids Therapy that payment is due at the time of service, unless other financial arrangements are made in advance. We require all guardians to pay their deductible, copay and/or coinsurance payment at the **beginning of each visit**. If you discharge or end therapy and your child's balance exceeds $100, a late fee of 10% will be added to the balance.

Although we are contracted with most insurance carriers, our services may not be covered by your insurance plan. Being referred to our clinic by another physician does not guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred. Your physician's referral and the verification of your insurance benefits are not a guarantee of payment.

I, (print) _____ do hereby acknowledge and agree to the terms set forth by my insurance policy regarding coverage/benefits for services. Billing is done as a courtesy; I authorize the release of any information for the above patient in order to process claims. If any services are not covered by my insurance, payment for these services will be my responsibility. Additionally, it is my responsibility to know and understand my coverage/benefits for treatment. Payment is due upon services rendered.

Signature: _____ **Date:** _____

TLC Staff Member: _____ **Date:** _____

Photo Release for Minor Children (Under 18)

I hereby grant Robbie Dunn and the employees of TLC Kids Therapy the right to photograph my dependent child and use the photo and/or digital reproductions of him/her or other reproductions of his/her likeness for publication processes, whether electronic, print, digital or electrical publishing via the internet.

Patient's Name: _____

(Please Print)

I certify that I am the custodial parent and have the aforementioned rights to assign.

☐ I give permission to photograph my dependent child.

☐ I decline permission to photograph my dependent child.

Signature of Parent/Guardian: _____ **Date:** _____

Printed name of Parent/Guardian: _____

Emergency Contact

Child's name: _____ Date of Birth: _____

Emergency contact's name: _____ Relationship: _____

Phone Number: _____ Alternate Phone Number: _____

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

Emergency contact's name: _____ Relationship: _____

Phone Number: _____ Alternate Phone Number: _____

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

Authorized Alternative Adult to Pick up your Child

Name: _____

Relationship: _____ Phone Number: _____

Name: _____

Relationship: _____ Phone Number: _____

TLC Kids Therapy has my permission to release my child into the care of _____ if I am unable to pick up my child from his/her therapy session.

Signature: _____ **Date:** _____

Illness Policy

Fever: A child will be sent home if their temperature is 100 or higher, and must stay home the next day for observation. Children must be free of fever (any temperature above 98.6 degrees) for at least 24 hours without the use of fever reducing medication.

Children suffering from a common cold will be assessed on an individual basis, dependent on our ability to limit the spread of germs.

Rash: Any rash other than a common diaper rash or skin irritation will require that child to be sent home. They may return with written clearance from a doctor that it is not contagious.

Conjunctivitis (pink eye): Children will be sent home if there appears to be an unusual amount of discharge from, or irritation to, their eye(s). They may return with written clearance from a doctor that it is not contagious.
BACTERIAL CONJUNCTIVITIS children must have received at least 24 hours of treatment.
VIRAL CONJUNCTIVITIS children may return AS LONG AS THERE IS NO DISCHARGE.
If, in fact, they do not have “pink eye”, we need a doctor’s note with a diagnosis and clearance that it is not contagious.

Thick White, Green, or Yellow Discharge: Children will be sent home if they appear to have any thick white, green, or yellow discharge. This is often indicative of an infection. They may return with written clearance from a doctor that it is not contagious, and at least 24 hours of treatment.

Diarrhea: Children will be sent home if they have three or more loose bowel movements in one day. Children must be free from diarrhea for 24 hours with at least 1 regular bowel movement. If your child has one or more loose bowel movements on their first day back, they will be sent home again.

Vomiting: Children will be sent home if they vomit and must stay home the next day for observation. Before returning to therapy (after the day of observation), children must symptom-free, with no vomiting for at least 24 hours.

Persistent Hacking Cough: Children will be sent home if they have a persistent hacking cough. They may return with written clearance from a doctor that it is not contagious.

Lice: Children will not be readmitted until 24 hours after treatment, and must be nit free.

Signature: _____ **Date:** _____

Patient Release of Medical Records

Patient's Name: _____ DOB: _____

To whom it may concern:

I authorize the release of Medical Records for:

☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy ☐ ABA Therapy

Additional Records to be released:

_____

_____

_____

The Medical Records as listed above are to be released to:

TLC KIDS THERAPY

502 E. Ramsey Rd

San Antonio, TX 78216

Phone: (210) 490-3900

Fax: (210) 490-3911

Signature: _____ **Date:** _____

(Parent or Guardian's signature if patient is a minor.)

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This form provides a condensed explanation; a more thorough version is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services and HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies: Patient information will be kept confidential except as is necessary to provide services, or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff.

- You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. The practice may utilize vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

- You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the therapist.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, (print) _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ **Date:** _____

PREGNANCY/BIRTH HISTORY

Length of pregnancy: _____

List any medications taken during pregnancy: _____

_____

Did the mother experience any complications during pregnancy? _____

_____

Weight at birth? _____ APGAR Score (if known) _____

Place of birth: _____

Birth conditions (circle applicable): Vaginal C-Section Breech Forceps

Did your baby spend time in NICU? Yes _____ No _____ How long? _____

Has your baby had any surgeries? Yes _____ No _____ If yes, please explain: _____

_____

_____

Does your baby have any chronic illnesses? Yes _____ No _____ If yes, please explain: _____

_____

Please list over the counter or prescription medications that your baby is currently taking:

_____

Does your baby have problems eating? _____

Does your baby have problems sleeping? _____

Please list therapy your child has received before this appointment (clinic, date and duration, and which discipline: _____

_____

CURRENT CONCERNS

Please describe your main concerns and the reason for this visit:

_____

_____

_____

_____