Kidz Therapy Zone
1101 Central Expressway S. Suite 185
Allen, TX 75013
Phone (214) 509-6961
frontdesk@kidztherapyzone.com

NEW PATIENT REGISTRATION FORM FOR INFANTS

PATIENT INFORMATION

Last Name:	First Name:	MI:
Date of Birth:	Age:	☐ Male ☐ Female
Street Address:	City:	State/Zip:
ISD:	School:	Grade:

PARENT / GUARDIAN INFORMATION

Mother's Name:		Lives with patient ☐ Yes ☐ No
Street Address (if Different):		
City:	State:	Zip:
Best Number to Reach You:		
Employer:	Work Number:	Email:

Father's Name:		Lives with patient ☐ Yes ☐ No
Street Address (if Different):		
City:	State:	Zip:
Best Number to Reach You:		
Employer:	Work Number:	Email:

INSURANCE INFORMATION

INSURED (check one) Using Insurance ☐ Self-Pay ☐

Subscriber Name:		Date of Birth:
Insurance Co:	Policy Number:	Group Number:
Telephone #:	Relationship to Patient:	Effective Date:
Secondary Insurance Co.:	Policy Number:	Group Number:
Telephone #:	Effective Date:	

CHILD'S REFERRING PHYSICIAN	
Family Pediatrician:	Telephone #:
Are there any other specialists your child is seeing? Please list.	

OFFICE VISIT	
Please indicate if someone other than a parent will be bringing your child to their appointments:	
Name:	Telephone Number:

A. BIRTH HISTORY					
Labor and Delivery	(check one)		Prenatal complications or concerns	(check one)	
Full Term Birth	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Pre-Term Birth	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No
Small for Gestation	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Birth Length		inches	Trauma	☐ Yes	☐ No
Birth Weight	lbs.	ozs.	Medications	☐ Yes	☐ No
Forceps	☐ Yes	☐ No	Drug Use	☐ Yes	☐ No
Cesarean Section	☐ Yes	☐ No	Alcohol Use	☐ Yes	☐ No
Infections	☐ Yes	☐ No	Tobacco Use	☐ Yes	☐ No
			Miscarriages	☐ Yes	☐ No
			Rash/Infections/Fever	☐ No	☐ Yes
			Toxemia	☐ Yes	☐ No

A. NEONATAL HISTORY		
HT/WT/Head Circ. Appropriate for Gestation Age	☐ Yes	☐ No
Respiratory Distress/ Oxygen	☐ Yes	☐ No
Hypoglycemia/Coma	☐ Yes	☐ No
Feeding Problems	☐ Yes	☐ No
Eye Exam	☐ Yes	☐ No
Apnea/Seizures/Low Muscle Tone	☐ Yes	☐ No
Hearing Screen	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Duration of hospital stay:		

B. DEVELOPMENTAL HISTORY					
Excessive Quietness	☐ Yes	☐ No	Hyperactivity/irritability	☐ Yes	☐ No
Colic after 2 months	☐ Yes	☐ No	Altered sleep /wake cycles	☐ Yes	☐ No
Did not like being cuddled	☐ Yes	☐ No	Floppiness	☐ Yes	☐ No
Feeding Problems	☐ Yes	☐ No	Stiffness	☐ Yes	☐ No
Late sitting, walking, talking	☐ Yes	☐ No			

B. DEVELOPMENTAL HISTORY	
Indicate approximate age which the following developmental milestones were reached.	
Crawling	
Sitting (unsupported)	
Walking	
Talking (mama, dada)	
Talking – own name	
Talking- short sentences	
Toilet Training	

C. IMMUNIZATION HISTORY

Received all vaccinations:	☐ On time	☐ Delayed	☐ Selective	☐ Did not vaccinate at all

D. DEVELOPMENTAL CONCERNS

Will follow your pointing to an item	☐ Yes	☐ No	☐ Sometimes
Overreacts to noises	☐ Yes	☐ No	☐ Sometimes
Overreacts to food textures	☐ Yes	☐ No	☐ Sometimes
Has difficulty tolerating light	☐ Yes	☐ No	☐ Sometimes
Has difficulty tolerating clothing	☐ Yes	☐ No	☐ Sometimes
Has difficulty with baths including washing hair	☐ Yes	☐ No	☐ Sometimes
Sleep issues	☐ Yes	☐ No	☐ Sometimes

E. ADAPTIVE HISTORY

Feeds self with fingers	☐ Yes	☐ No	☐ Sometimes
Feeds self with spoon/fork	☐ Yes	☐ No	☐ Sometimes
Uses cup	☐ Yes	☐ No	☐ Sometimes

H. MEDICAL, ALLERGIES AND INTOLERANCES

Are there any food allergies, seizures, medications or medical conditions which might affect your child's ability to participate in testing or therapy activities? If yes, please describe and provide emergency information. (e.g. epi pen, seizure precautions, inhalers, latex allergies, profound carsickness, etc.) Please describe:	☐ Yes	☐ No
Does your child require glasses	☐ Yes	☐ No
Does your child wear hearing aids?	☐ Yes	☐ No
Does your child have special shoe inserts?	☐ Yes	☐ No
Does your child have any medical problems? Please list below:	☐ Yes	☐ No
Does your child currently take medications or supplements? Please list below: Name – dosage:	☐ Yes	☐ No

I. CHIEF COMPLAINT

What are the reasons you are visiting our office?

Describe your child's daytime schedule / nighttime schedule:
What do you hope your child will accomplish in an occupational or physical therapy program?

J. DISABILITY OR DIAGNOSIS

Has your child been diagnosed with a disability? If yes, please indicate below. ☐ Yes ☐ No
Is your child receiving other therapies or tutorials? Have they ever received occupation or physical therapy services at any time? Please describe below. If they received services, but the services were terminated please also describe below.

K. FAMILY LIFE and INFORMATION

Please list sibling names and ages:

L AUTHORIZATION TO TREAT PATIENT

I agree to give "KIDZ THERAPY ZONE" consent for care and treatment considered necessary and proper in evaluation and treating my condition. I authorize "KIDZ THERAPY ZONE" to treat me and use my personal health information for healthcare operations. I have reviewed the posted HIPPA privacy policy and a copy of the policy has been offered to me.

I agree my insurance benefits have been verified by "KIDZ THERAPY ZONE" and have been explained to me from the information collected by my insurance plan. However, the information that was given by the insurance: by paper, by insurance recorder or by representative over the phone is "NOT A GUARANTEE OF PAYMENT". Verification is a courtesy by our clinic and we cannot be held responsible for the benefits told. We do ask that our client's insured also call their insurance to verify coverage.

Signature (Parent or Insured) _____ Date:_____

M. RELEASE

Permission is specifically granted to release information to: your insurance for billing purposes and to your doctor who referred your child for treatment. But, if you have any other releases you want approved, please list below: (Such as: treating therapist, teachers, physicians, other insurance companies etc….)

Name:	
Address:	
Title:	
Phone:	

Name:	
Address:	
Title:	
Phone:	

☐ I do NOT give permission for Kidz Therapy Zone LLC to release information regarding my child.

☐ I give permission for Kidz Therapy Zone LLC to release information regarding my child when necessary.

☐ I give Kidz Therapy Zone permission to post a picture of my child on the bulletin board in our office.

Name Date

N. ATTENDANCE AND CANCELLATION

Effective care requires a commitment from the child's family. Regular attendance is necessary to therapy sessions to be meaningful and effective. Working together as a team, we can accomplish the best outcomes for your children and family. Reasons for absence should therefore be limited to parent or child illness or other family emergency situations.

If you or your child is ill, we prefer that you cancel rather than spread illness. Exposure to upper respiratory infections, strep throat, flue, chicken pox and other infectious diseases are dangerous to come of our students and adults. You will not be charged for those cancellations. However, you must call the office prior to your appointment time to cancel or reschedule your appointment. If you miss an appointment without cancelling in advance you will be charged the full cost of your appointment. If your credit card is on file, it will be charged at the time of the missed appointment. If your card is not on file, payment for the missed appointment will be due at the time of your next visit.

If you are running late for your appointment please call. When you arrive your appointment will consist of the time left of the schedule appointment *unless* the schedule allows for the full scheduled amount of time. In either case the regular fee for the appointment will be charged.

_____ Please initial here indicating your acknowledgement of this policy.

If your child is absent from therapy frequently, it may be necessary for your therapist to discontinue your appointed time in order to make the time slot available to another patient. We encourage you to communicate frequently with your therapist in order to best accommodate your child's particular needs and try to prevent disruptions in your child's care.

O. FINANCIAL POLICIES

Payment is due at the time of service.

In a situation where the child's parents are divorced or separated, it is our policy that the parent who has arranged the sessions is ultimately the responsible party. We will require written authorization from the other party should they be intending to pay for the therapies. We will not bill another party (parent, grandparent) without their prior authorization.

Kidz Therapy Zone appreciates the confidence you have shown in choosing us to provide your health care needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. Your insurance is a method for you to receive reimbursement for fees you pay for therapy. Having insurance is not a substitute for payment. We typically have a fixed allowance or percentage we charge based on our contract with insurance companies. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid by your insurance which may include services verified by your insurance as being covered by your plan that are ultimately not covered by your insurance provider. Many insurance companies have additional stipulations that may affect your coverage. We will do our best to determine if there are exclusions on your policy and inform you of such findings; however, it is ultimately the patient's responsibility to know your coverage and benefits, but you are responsible for your child's bill if your insurance has not reimbursed Kidz Therapy Zone within 60 days of submission to them. Delinquent accounts will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees / attorney's fees.

It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at Kidz Therapy Zone.

Your initial below indicates you have read the Financial Policy explained above and assume full financial responsibility.

_____ Please initial here indicating your acknowledgement of this policy.

We have specific therapists perform initial evaluations. Based on the outcome of the evaluation we pair the therapist which will match best personality and skill level wise. We make every effort to ensure your child sees the same therapist every visit. However, there are those occasions when a therapist is ill or on vacation and another certified therapist will fill in temporarily. This is done automatically. Such cases are minimal.

_____ Please initial here indicating your acknowledgement of this policy.

P. NOTICE OF INFORMATION PRACTICIES AND PRIVACY STATEMENT

Kidz Therapy Zone LLC (KTZ) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between KTZ and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.kidztherapyzone.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of KTZ. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Please sign below indicating that you have read and understand these policies.

Name: _____

Name (Print): _____

Date: _____

Q. OFFICE INFORMATION

When you first arrive at the office we ask you sign in at the receptionist's desk and notify us of any changes in address or insurance information.

We also request any co-payment or deductible be paid at this time. Payment is due at the time of service.

In order to retain a safe, clean and confidential office we have the following necessary office policies and courtesies.

R. FACILITY SAFETY:

NO ONE MAY ENTER THE TREATMENT AREAS UNDER ANY CIRCUMSTANCES unless accompanied by your child's therapist. This is not a request, but a firm policy. Our extensive equipment, while enticing, has its inherent dangers and precautions. This policy applies to everyone: parents, caregivers, patients, siblings and friends. No one is permitted to wander through our facility, nor to use any equipment during your child's treatment times.

We maintain a large, comfortable waiting room with a play area where parents, caregivers, siblings and friends may relax during the time when your student is with their therapist.

If a parent or caregiver is participating in the treatment session with your child and their therapist, it is still your responsibility to ensure that any siblings or friends who are present with you abide by these rules. It is for their safety, and necessary to protect us from possible liability. We need to focus our attention on your child during their treatment.

S. SNACKS AND THE WAITING ROOM:

Please keep snacks in the waiting room or take them with you as you exit. We understand that snacks and kids can be messy. For the comfort of all our patients we ask that you clean up if your child has created any food mess. And please do not bring in large, messy dinners like pizzas and meatball subs to eat while waiting for your child. Some children that come here are allergic to the smell and taste of peanuts so we ask as a courtesy that you please do not bring peanuts to the office.

Please treat our facility as you would your own home. If there are toys or food wrappers, dirty diapers or general mess that your family has created, please take the time to tidy up before you leave.

T. CONFIDENTIALITY:

We make every effort to maintain confidentiality. Some of the treatment areas have more than one therapist and student participating at a time. No photographs of your child are taken nor will we contact any parties to discuss your child without written consent. If you prefer to have privacy when discussing your child, please ask therapist to talk in a private space rather than the waiting room.