THERAPY ZONE 4 KIDZ

Client Information

Date of Initial Visit:_____ Referred by:_____

Client's Name:_____ Date of Birth:_____

Parent's Name(s):_____

Address:_____ City:_____ Zip:_____

E-mail Address:_____

Current Grade/School:_____

School Services Currently in Place (IEP, 504 Plan, Speech, Resource, Adaptive P.E.):

_____

_____

Diagnosis (if any): _____

Who is Responsible for payment?_____

Parents Name (Mom /Dad) (please circle)	Home Phone	Cell Phone	Work Phone
	( )	( )	( )

Parents Name (Mom /Dad) (please circle)	Home Phone	Cell Phone	Work Phone
	( )	( )	( )

Which number should be called first to best reach you?_____

Is it O.K. to leave a confidential message at this number? (please circle): Yes No, just leave a call back #.

If parents live at two different addresses, please provide other address below:

_____

Please list any Allergies, Precautions or Current Medications your child has (please include any food allergies):

_____

_____

Primary Concern(s) of the child/family:

1.

2.

3.

Therapy Zone 4 Kidz
17705 Hale Ave. Suite C-4
Morgan Hill, Ca. 95037, (408) 334-0400

DEVELOPMENTAL HISTORY AND BACKGROUND

Child's Name:_____Date:_____
Birthdate:_____

Current areas of concern (mark all that apply)

___Gross motor development	___Sports	___Fine Motor Development
___Handwriting	___Pencil Grip	___Language
___Social Skills	___Eating	___Sleeping
___Reading	___Spelling	___Math
___Motivation	___Moodiness	___Neatness
___Getting along with peers	___Self-confidence	___Attention/Focus
___Getting along with adults	___Easily Frustrated	___Fearful

Self-Care Skills

I = Independent
F = Frustration interferes with completion
D = Dependent
A = Attention interferes with completion

____Toileting- wipes self	____Washes/dries hands
____Manages clothing for toileting	____Hair washing
____Undresses	____Hair brushing
____Dresses	____Brushes teeth
____ Shower	____Uses fork/spoon
____Buttons	____Cuts with Knife/fork
____Zippers	____Finger foods
____Ties shoes	____Uses open cup
____Velcro	____Socks on/off
____Uses a straw	____Bath

Has your child had any of the following examinations? If so, please give the approximate date and the examining person's name and place of business name:

	DATE	BY WHOM	BUSINESS
Last physical examination:			
Neurology			
Psychiatry			
Psychology			
Education			
Speech and Hearing			
Occupational Therapy			
Other special examinations			

Please check the column which best describes your child. After each item and category, please write any remarks or comments that you feel may be helpful. Please include child's strengths in comment area.

BEFORE BIRTH:	YES	NO	REMARKS
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operation or any other difficulties?			

	YES	NO	REMARKS
2. Were any drugs or medications taken during pregnancy? Specify.			
DELIVERY:			
1. Was the pregnancy full term?			
2. Was the pregnancy premature?			
3. Was it an unusual delivery? (i.e.,Breech, Caesarean,)			
4. Was the labor normal?			
5. Was the labor abnormal? (Prolonged, short, specify)			
6. Were forceps used?			
7. Was medication given during delivery? Specify.			
BIRTH:			
1. Was your child considered to be a low birth weight? Specify.			
2. Were there complications such as:			
a. Cyanosis			
b. Jaundice			
c. Congenital defects			
d. Limpness			
3. Was there a need for:			
a. Oxygen			
b. Transfusion			
c. Tube feedings			
4. Were there any feeding difficulties? Specify.			
5. Was the child bottle fed?			
6. Was the child breast fed?			
7. Did the child have problems sucking?			
MEDICAL HISTORY:	**YES**	**NO**	**SOMETIMES**
1. Has your child had any of the following:			
a. Meningitis			
b. Measles			
c. Chicken pox			
d. High fevers			
e. Mumps			
f. Whooping cough			
g. Scarlet fever			
h. Convulsions			
i. Diabetes			
j. Lung or bronchial difficulties			
k. Heart trouble			
l. Seizures (indicate when, how often)			
m. Allergies			
n. Excessive vomiting			
o. Tuberculosis			

	YES	NO	SOMETIMES
p. Polio			
q. Physical Injuries (if yes, please describe)			
1. Does your child have a vision problem?			
2. Has your child had an eye evaluation? Date of Exam			
3. Does your child have a hearing problem?			
4. Has your child had a hearing evaluation? Date of Exam			
5. Is your child currently on medication? If yes, give a list and state reasons			

DEVELOPMENTAL HISTORY:	AGE
1. At what age did your child: (please specify ages as near as possible)	
a. Roll over both ways?	
b. Sit alone?	
c. Walk?	
d. Speak his first word (what was it)?	
e. Speak his first sentence (what was it)?	
f. Drink from a cup independently?	
g. Use a spoon independently?	
h. Feed himself independently?	

2. Describe your child as an infant	YES	NO	SOMETIMES
a. Cries often, fussy, irritable			
b. Is good, non-demanding			
c. Is alert			
d. Is quiet			
e. Is passive			
f. Is active			
g. Likes being held			
h. Resists being held			
i. Is floppy when held			
j. Is tense when held			
k. Has good sleep patterns			
l. Has irregular sleep patterns			
3. Describe your child at present			
a. Is mostly quiet			
b. Is overly active			
c. Tires easily			
d. Talks constantly			
e. Too impulsive			

	YES	NO	SOMETIMES
f. Is restless			
g. Is stubborn			
h. Is resistant to changes			
i. Over reacts			
j. Fights frequently			
k. Is usually happy			
l. Exhibits frequent temper tantrums			
m. Is clumsy			
n. Has difficulty separating from primary caretaker			
o. Has nervous habits or tics			
p. Falls often			
q. Is frustrated easily			
r. Has unusual fears			
s. Rocks self frequently			
t. Has difficulty learning new tasks (i.e., using a toy)			
u. Has poor attention span			
Language:			
1. Does your child seem to understand what is said to him?			
2. Did your child start to talk and then stopped?			
SENSORY HISTORY:	**YES**	**NO**	**SOMETIMES**
Auditory:			
Does your child			
1. Respond negatively to unexpected or loud noises?			
2. Have difficulty paying attention when there are other noises nearby?			
3. Miss hearing some sounds?			
4. Seem confused as to the direction of sounds:			
5. Seem to enjoy strange noises and/or make loud noises:			
6. Appear to be hard of hearing"			
7. Enjoy music"			
8. Get distracted by ambient noise (lights, air condit.)?			
Gustatory-Olfactory-Elimination:			
Does your child			
1. Act as though all food tastes the same?			
2. Chew on non-food objects?			
3. Is your child a "picky eater"?			
4. Have unusual cravings for certain foods:			
5. Dislike food of certain texture?			
6. Explore by smelling?			

	YES	NO	SOMETIMES
7. Discriminate odors?			
8. React negatively to smell?			
9. Ignore unpleasant odors?			
10. Have trouble with constipation?			
Visual:			
Does your child			
1. Appear happier in the dark?			
2. Pick up pictures or objects and look very closely and carefully at them?			
3. Resist having eyes covered?			
4. Becomes excited when there are a variety of visual objects?			
5. Squint often?			
6. Have difficulty with focusing on things far away?			
7. Have difficulty with visually focusing on things close?			
8. Have trouble with reading?			
Tactile:			
Does your child			
1. Avoid playing with "messy" things, i.e., finger paint, paste, mud, sand, etc.			
2. Dislike having his face washed or wiped?			
3. Appear to be irritated by cloth of certain textures? Specify.			
4. Dislike wearing shoes and/or socks			
5. Object to being touched?			
6. Dislike being touched unexpectedly?			
7. Dislike being cuddled?			
8. Prefer to touch rather than be touched?			
9. Avoid using hands for extended periods?			
10. Bang his head on purpose now or in the past?			
11. Pinch, bite or otherwise hurt himself?			
12. Examine objects by putting them into his mouth?			
13. Tend to feel more or less pain than others? (circle one)			
Motor:			
Does Your child			
1. Appear clumsy/avoid balance activities?			
2. Seems to have excessive energy?			
3. Bump into people/objects?			
4. Break toys easily/crush things?			
5. Seeks running/crashing/jumping?			
6. Appear to have "aggressive" behavior?			
7. Have trouble following/understanding directions?			
8. Spin/twirl excessively?			

	YES	NO	SOMETIMES
9. Have car sickness?			
10. Have "soft" muscles/low tone?			
11. Tantrums easily/overly emotional?			
Can your child			
1. Hop on one foot?			
2. Skip?			
3. Jump with both feet together?			
4. Ride a tricycle?			
5. Ride a two wheeler with or without training wheels?			
6. Pump self on the swing?			
7. Kick a ball?			
Does your child exhibit difficulty with			
1. Cutting or pasting?			
2. Playing with small manipulative toys?			
3. Learning to hold a pencil or crayon with a 3 finger grasp?			
4. Learning how to use playground equipment?			
Comments:			
Social Adjustment:			
Does your child			
1. Calm down independently?			
2. Find it hard to make friends among his peers?			
3. Prefer the company of adults, or older children?			
4. Prefer to play with younger children?			
5. Frequently express feeling of failure or frustration?			
6. Play with toys appropriate for his age?			
Comments:			
School Performance:			
1. Does your child:			
2. Need to prop his head in his or her hand while reading or writing at the desk?			
3. Mix up which hand or foot is left or right?			
4. Know which hand is dominant?			
5. Make reversals of letter or numbers when writing?			
6. Read words in reverse?			
7. Finds PE or sports to be a difficult experience?			
8. Have any learning problems? Be specific.			
Comments:			

*adapted from the Ayers Clinic Development History for Sensory Integration

Therapy Zone 4 Kidz
Policies and Fees

Thank you for allowing **THERAPY ZONE 4 KIDZ** to help your child. I strive to provide excellent care in helping your child succeed in play and in life. I aim to provide a high quality of service to the child and their family.

Services Available and Fees

Assessments

Each child that receives services with **THERAPY ZONE 4 KIDZ** is asked to have a recent assessment of their skill level. A report from another occupational therapy agency, completed within 6 months of therapy start date, would be sufficient. If no current assessment has been completed, we will determine the need for an assessment based on the child's level of performance and the needs of the family

Evaluations/Consultations with Report: $650
An evaluation includes direct treatment with a minimum of 2 hours of testing using standardized tests, as appropriate, and clinical observations. Also included is a record's review and consultation with the parents/caregiver and other team members (per requested) in order to gain more information about the child. A comprehensive written report will be provided which will include a one hour parent conference to discuss test results and plan for therapy. Half of the assessment cost is due on the first day of assessment with the remaining balance due once the report is complete.

Individual Therapy: $130 per session
Individual therapy consists of a 50 minute direct therapy hour. The remaining 10 minutes will be used for documentation of the therapy session and/or any extra clean-up or set-up time that is required for a child. There may be times when extra time is needed to consult with the therapist and/or share pertaining information with the therapist. On such occasions, time should be set aside within the 50 minutes treatment time to discuss any questions or information you may have. Please see "Additional Consultation" for other options.

Additional Consultation: $130 per hour

If additional consultation time is needed, with family or another team member, it will be billed at the hourly rate. This consultation time can be scheduled as a phone conference or a separate meeting. This charge will be added to payment on your child's next session.

Reports (Progress Reports or Reports needed for Insurance Reimbursement): $130/hr.
Written reports requested will incur a charge based on the hourly rate. It is asked that at least two weeks be given to complete the requested document.

School Consultation $160 per hour
School consultations, trainings and meetings can be scheduled in order to discuss your child's strength's and weakness' with the school staff and to promote academic achievements and decreased behavioral issues. Every effort will be made to accommodate your request: however, availability of therapist is limited.

Policies

Payment
Payment is due at the time of service in the form of cash or check. I do not work directly with insurance companies and do not bill your insurance for you. At the time of payment you will receive a receipt that includes treatment codes that can be used for reimbursement. Insurance coverage is not guaranteed and varies among insurance companies and plans.

In the event of a returned check, you will be notified and alternate payment will be due within 10 business days of being notified. You will responsible for any bank charges incurred.

Any balance past due by more than 30 days shall be subject to interest charges of 10% and a possible discontinuation of service. Non payment of services that are 6 months delinquent may be reported to a collection agency.

No Shows/Cancellations
In the case of an appointment missed without sufficient notice or no notice at all will be billed for the full cost of the session. Cancellations require at least 24 hours notice, less than 24 hours notice will incur a charge of the full therapy session. If your child is sick please see "cancellations due to illness".

Cancellations Due to Illness
You may not know that your child is sick until the morning of your appointment. Please make every effort to notify the clinic, leaving a message if there is not answer, no later than 7:30 a.m. on the day of your appointment. A fever indicates your child is sick and also contagious. If your child has a fever the day before your appointment, it is necessary that the appointment be cancelled. If possible, please call the day before to notify the clinic and to cancel your appointment.

Missed Sessions
There are times when you may need to cancel your therapy session due to illness, vacation, schedule conflict etc. Due to the high demands of running a clinic and in order to avoid rate increases, I must ensure that my scheduled treatment times are filled. You are allowed to cancel 1 session during the fall semester, 1 session during the spring semester and 1 session during the summer without any penalty. Any cancellation beyond the limit will incur a charge of ½ the regular session rate. Cancellations in excess may result in a discontinuation of therapy.

- Fall Session: Sept-February
- Spring Session: March-May
- Summer: June-August

The clinic will be closed for the following holidays:
- Thanksgiving (Thursday and Friday)
- 2 weeks for the winter holiday (December/January)
- Fourth of July
- Labor Day
- Memorial Day
- **Winter break (scheduling an appointment is optional)
- **Spring Break (scheduling an appointment is optional)

** Dates are in conjunction with Morgan Hill school district. For the weeks of optional scheduling, cancellations for that week will not count towards a missed session. However, once a session is scheduled for that week, any cancellation or no show will be counted as such.

Late Pick-up
I typically have sessions back to back, therefore, it is very important for you to be at the clinic at the end of the session to pick up your child. If you plan to leave the clinic for your own personal time, I require that you leave your cell phone number to contact you in case of an emergency. Therapy sessions run 50 minutes in length, in the event that you are late to pick up your child, you will be charged at the regular therapy rate for any time beyond the initial 50 minutes. This policy is in place for your child's protection. Given that sessions run back to back, I am unable to watch your child during another child's therapy time. If you are late you will be billed the hourly rate for each 15 minutes.

Discontinuation of Service/Refusal of Service
If you choose to discontinue therapy, you will need to provide at least two weeks notice prior to your last therapy session. The last two weeks of therapy will be covered by your registration fee. Any cancellation within that time, for whatever reason, will be billed at the full therapy rate. Service may be refused or discontinued due to non-payment, aggressive behavior, lack of progress or lack of cooperation of the child or parent.

Waiting Room Policy
In order to maximize therapy space I do not have a typical waiting room. To maintain privacy for families, **PLEASE DO NOT ENTER THE BUILDING UNTIL THE START OF YOUR SCHEDULED THERAPY TIME**. For safety concerns and to maintain the flow of the therapy session, siblings are not allowed in the gym space during your child's therapy time. There are many places close by to visit (i.e., park, coffee shop, 7-11 etc.). Parents are invited to observe and participate (as needed) in their child's therapy session. This is, however, dependent on your child's behavior during the session and can be discussed further when sessions begin.

Therapy Zone 4 Kidz
Informed Consent for Occupational Therapy Treatment

In connection with the occupational therapy program at Therapy Zone 4 Kidz in which my child _____ will be participating, I hereby consent to the following (please initial in the boxes below indicating you have read and consent to each of the statements listed below):

☐ By initialing this box, I indicate that I have read and received a copy of the Therapy Zone 4 Kidz Notice of Privacy Polices and authorize use and disclosure of my child's health information for treatment, payment and healthcare operations, and that I have received a copy of the Policies and Fees and all my questions have been answered.

☐ I understand that occupational therapy is a joint effort, the results of which cannot be guaranteed. Progress depends on many factors, including the neurological make-up of the individual, motivation, effort, follow-through with recommended activities for home, and other life circumstances. Even after such efforts, in some instances, only minimal progress may be noted.

☐ I understand that there may be times Galvan Park may be used as part of the therapy session and, while every effort will be used to prevent injuries, injuries may occur and the city of Morgan Hill is not liable or responsible for any injury that may occur during such time.

☐ I understand certain approaches may require hands on treatment and/or physical engagement of both therapist and child. While every effort is made to prevent injuries, injuries may occur during treatment.

☐ I understand that Therapy Zone 4 Kidz may use information about my child in educational presentations, provided that my child's identity or any clues to my child's identity are not revealed.

☐ I understand that information and records, and/or testimony, otherwise confidential, must be provided in the event of a court order or in litigation or official proceedings, in accordance with applicable law.

☐ I understand that my child will receive occupational therapy for 50 minutes per session at the rate of $130 per session. I understand that I am responsible for therapy charges and that payment is due on the day of services.

Parent/Guardian Signature **Date**

Relationship to Child

Therapy Zone 4 Kidz
Emergency Medical Release

In the event of my absence or inability to provide consent, I hereby give my permission for my therapist to seek the appropriate emergency medical attention for my child_____.
(print child's name)

In the event of an emergency, please provide any special instructions needed (including allergies, medications, special medical needs etc.)

_____
_____
_____
_____
_____
_____

Print Name

Parent/Guardian Signature **Date**

Pick-Up Release

The following people have my permission to pick up _____
(print child's name)
after the therapy session. Please list all names of people picking up your child and their relationship to the child:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Parent/Guardian Signature **Date**

Therapy Zone 4 Kidz Privacy Policy

The purpose of this notice is to describe:

- How health information about your child may be used and disclosed
- How you can get access to your child's health information
- How the privacy of your child's health information is important to us

Please review this notice carefully

Terms:

Any medical information, which could in any way identify an individual client, is considered **Protected Health Information (PHI)**. PHI will be used and disclosed only as needed for Therapy Zone 4 Kidz to perform **Treatment, Acquire Payment and Health Care Operations (TPO)**. We are required by federal and state law to maintain the privacy of your child's health information. We are also required to give you this notice about our privacy polices and practices, our legal duties, and your rights concerning your child's health information. We will follow the privacy practices described in this notice while it is in effect. This notice will remain in effect until we replace it.

We reserve the right to change our organization's privacy policies and practices and the terms of this notice at any time, as permitted by federal and state law. We reserve the right to make changes in our privacy policies and practices and to make the new provisions effective for all protected health information that we maintain. If changes are made, the new notice will be available upon request and will be posted at our site.

In order to maintain the privacy of all client information, no one should enter the office area unless accompanied by clinic personnel. Family members should be in the treatment area only when accompanying their child.

Patient/Client Rights:

Access:

The following people will have access to PHI

- The client when 18 years or older
- Parents or legal guardians of a minor.
- Parent of an adult client with written permission of the client.
- Any person to whom the parent or legal guardian has authorized, in writing, the release of PHI
- Therapy Zone 4 Kidz staff who are involved in providing care or administrative assistance.
- The clients' health insurance company, for payment purposes.
- Public Health Services and regulatory officials, when required by law.
- An appropriate authority when a determination is made that the client may pose a physical threat to themselves or others.
- Courts, when the request is accompanied by a duly executed subpoena

You have the right access your child's health information. You can request to view it and/or have us make photocopies (for a cost) of the information you desire. All requests for access to your child's health information must be in writing and an appointment time will be set. In certain specific circumstances we may deny your request, but we will tell you in writing of our decision and any reason(s) for the denial. Please contact Deborah Neargarder for the required form. Amendment: You have the right to request that we amend your chills health information. All requests to amend your child's health information must be in writing including an explanation of why you want the record amended. Please contact the privacy contractor, Deborah Neargarder for assistance. We may deny your request if the information:

1. Was not created by Therapy Zone 4 Kidz (e.g. a report from another professional)
2. Is not part of the protected health information we keep
3. Is determined by Therapy Zone 4 Kidz to be accurate and complete

If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint that can become a part of your child's record.

Security:

Privacy measures are designed to protect the confidentiality of all PHI:

- Therapy Zone 4 Kidz staff will receive instruction about and be familiar with current privacy policies
- Every effort will be made to avoid being overheard when discussing PHI
- All records will be maintained in a s secure environment

Grievances:

For all questions, concerns or complaints please address them to Deborah Neargarder. You may also submit a written complaint to the U.S. Department of Health and Human Services. Therapy Zone 4 Kidz will not retaliate against any individual for filing a complaint.

Additional Health Information:

Health Privacy Project	Office for Civil Rights
Georgetown University	U.S. Department of Health & Human Services
www.healthpirvacy.org	www.hhs.gov/ocr/hipaa/

Please Read the privacy policy and initial the box on "Informed Consent For Occupational Therapy treatment". You may retain this copy for your records.