Kidspiration

Pediatric Therapy Services

Offering Pediatric PT, OT, ST, ABA and Counseling

Outpatient Information Packet

Please Fill Out and Return to Kidspiration

Please check the areas below that you are interested in having your child evaluated in:

Speech Therapy: ☐

Occupational Therapy (Fine Motor): ☐

Physical Therapy (Gross Motor): ☐

Child's Name: _____

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Explanation of Therapists

We have several therapists here at Kidspiration. Each therapist is valued and is an important part of your child's daily life.

Below are some quick references as to what they do with your child.

Occupational Therapist

An occupational therapist is someone who works on fine motor skills like holding a crayon and cutting with scissors. They also work on cognitive development. An OT primarily works on skills for everyday life such as eating and dressing. Occupational therapists also work with children who have sensory needs.

Physical Therapist

A physical therapist is someone who works on gross motor skills like walking, running, jumping, etc. They also work on transitional skills such as sitting, balancing, mobility, crawling and standing.

Speech Pathologist

A Speech pathologist is someone who works with children on more than just talking. They help with communicating, emotions, eating, talking and signing.

Behavioral Therapist

A behavioral therapist is someone who uses behavioral approaches to reduce and eliminate emotional distress and unwanted behaviors that could be from adjustment issues, divorce, grief even trauma. Examples: oppositional and defiant, aggressive behavior and mood issues.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Kidspiration is required by law to maintain the privacy of your child's health and education information, to provide you a notice of our legal duties and privacy practices, and to follow the information practices that are described in this notice. We respect your privacy. We understand that your child and family's personal information is very sensitive. For example, your child's personal information includes demographics, treatment plans, documentation of diagnosis, and treatment records. Described as follow are the ways we may use and disclose information that identifies your child.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Treatment: We will use health information to provide treatment to your child. This includes use and disclosure of health information among KIDSPIRATION staff and volunteers as it relates to your child's treatment. In addition, with your written consent, we may disclose health information to your child's doctors, nurses, technicians, or other personnel, including other people who are involved in your child's medical care.

Payment: With your authorization, we may disclose health information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you child received. For example, we may provide your health plan with information including diagnosis, procedures performed, progress goals, or recommended care, so they will pay for your child's treatment.

OTHER USES AND DISCLOSURES

We may also use or disclose your child's information to meet special reporting requirements, for public health reasons, or for other purposes. Such disclosures permitted by law that do not require your written consent include:

- Family and friends involved in your child's care or payment.
- Disclosures to public health authorities to prevent or control disease.
- Disclosures to public authorities as part of a report of child abuse, neglect, or domestic violence.
- Data for health or educational oversight activities, such as audits, investigations or inspections.
- To avert a serious threat to health or safety or to prevent serious harm to an individual.
- To secure emergency medical treatment for your child in the event of an accident or injury.
- Participation in a qualifying research project
- As required by law, such as for law enforcement or in response to a lawful subpoena or count order.
- Coroners or medical examiners, as necessary, to carry out their duties.
- To provide you with information about treatment alternatives or new health-related services that may be of interest to you
- Appointment reminders

All other uses and disclosures will be made ONLY with your written authorization, which you have the right to revoke in most cases.

YOUR RIGHTS

You have the following rights regarding health and education information we have about your child:

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Notice of Privacy Practices Continued

Right to Inspect and Copy: You have a right to inspect and copy health information that may be used to make decisions about your child's care or payment for your child's care. This includes medical and billing records, other than psychotherapy notes. To inspect a copy of this health information, you must make your request in writing to our Executive Director.

Right to Amend: If you feel that the health or education information we have is inaccurate or misleading, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for KIDSPIRATION. To request an amendment, you must make your request in writing to our Quality Assurance Coordinator. While we accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures and a record of access regarding your child's health and education information. The list does not include disclosures we made directly to you, disclosures to friends/family members, disclosures you specifically authorized in writing, disclosures to third party payers or disclosures related to our daily business operations. To request an accounting of disclosures, you must make your request in writing to our Executive Director.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose. You also have the right to request a limit on the health information we disclose to someone involved in your child's care or the payment for your child's care, like a family member or friend. To request a restriction, you must make your request in writing to our Executive Director. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide your child with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Please contact our Executive Director to request confidential communication. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. This new notice will apply to health and education information we already have, as well as any information we receive in the future. We will post a copy of our current notice at our clinic. The notice will contain the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Education. To file a complaint with KIDSPIRATION, contact:

Director

Kidspiration

PO Box 2533

Mtn. Home, AR 72654

All complaints must be made in writing. You will not be penalized for filing a complaint.

Developmental Questionnaire

PLEASE FILL IN THE BLANKS OR CIRCLE THE CORRECT ANSWERS FOR EACH QUESTION.
ALL INFORMATION PROVIDED IN THIS FORM IS CONFIDENTIAL & USED ONLY FOR THE EVALUATION AND TREATMENT OF YOUR CHILD.

1. CHILD BASIC INFORMATION

Child's Full Name: _____ **DOB:** _____

Sex: _____ **Race:** _____ **City & State of Birth:** _____

Physical Address:

_____
STREET CITY STATE ZIP CODE

Mailing Address (if different from physical):

_____
STREET CITY STATE ZIP CODE

Physician: _____ **Clinic Name and location:** _____

Medicaid Number: _____ **Social Security Number:** _____

If your child is on a PASSE or has private insurance coverage please fill out that info below. You must provide us with a copy of your child's PASSE ID card and/or private insurance ID card

PASSE TYPE: SELECT ONE: **PASSE ID #:** _____

PRIVATE INSURANCE TYPE: SELECT ONE **Policy #:** _____

Group #: _____

2. PARENT/GUARDIAN INFORMATION

Mother/Guardian Name: _____ **DOB:** _____ **Last 4 of SS#:** _____

Phone: _____ **Email Address:** _____

Physical Address: ☐ Check box if same as child's

_____

Employer: _____ **Work Phone:** _____

Work Hours/Days: _____

Father/Guardian Name: _____ **DOB:** _____ **Last 4 of SS#:** _____

Phone: _____ **Email Address:** _____

Physical Address: ☐ Check box if same as child's

_____

Employer: _____ **Work Phone:** _____

Work Hours/Days: _____

3. FAMILY/HOME INFORMATION

Child Lives with:

☐ Both Parents ☐ Father ☐ Mother ☐ Guardian

Custody:

☐ Parent Live Together ☐ Shared Custody ☐ Parent/s Not Involved

Please Explain:

_____

Is there a court ordered custody arrangement? ☐ NO ☐ YES

If yes, please provide a copy of the court order for your child's file.

SIBLINGS:

Name:	Sex:	DOB:	Relationship

WHO LIVES IN THE HOME WITH YOUR CHILD?

Name:	Age:	Relationship to Child:

4. BIRTH HISTORY

Gestation Age at birth: _____weeks ***(We must know this for testing purposes.)***

Birth Weight: _____ Lbs. _____ Oz's.

Pregnancy Complications:

☐ Bed Rest ☐ Anemia ☐ Gestational Diabetes ☐ Early Labor ☐ None

Other: _____

Were any prescriptions, drugs, alcohol, or tobacco products used? ☐ NO ☐ YES

If yes, explain: _____

Birth Complications:

☐ Cord Around Neck ☐ Emergency C-Section ☐ Meconium Aspiration ☐ None

Other: _____

Delivery Type: ☐ Vaginal ☐ C-Section ☐ Hospital Birth ☐ Home Birth

Health at Birth: ☐ GOOD ☐ Complications: _____

NICU: ☐ NO ☐ YES Name of Hospital: _____

Length of Stay: _____ Reason: _____

5. MEDICAL HISTORY

Hospitalizations:

Reason: _____ Date: _____ Length of Stay: _____

Reason: _____ Date: _____ Length of Stay: _____

Surgeries:

Type: _____ Date: _____

Type: _____ Date: _____

Serious Illnesses:

Type: _____ Date: _____

Type: _____ Date: _____

Medications:

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Diagnoses:

☐ Autism/ASD ☐ ADHD ☐ CP ☐ Down Syndrome ☐ CF ☐ Asthma

Other: _____

What doctor/clinic gave the diagnosis: _____ Date of Dx: _____

Has your child seen a specialist (ex. ENT, Neurologist, Cardiologist, Allergist, etc.)?
☐ NO ☐ YES If yes, please explain: _____

Allergies?: ☐ NO ☐ YES *If yes, please provide written documentation from your child's doctor.*

Food: _____

Medications: _____

Environmental/Seasonal: _____

Does your child have an EpiPen or other emergency medication? ☐ NO ☐ YES

What happens when your child comes in contact with or consumes their allergen?

_____

Hearing Screening: ☐ NO ☐ YES SELECT ONE Hearing Aids: ☐ Y ☐ N

Vision Screening: ☐ NO ☐ YES SELECT ONE Glasses: ☐ Y ☐ N

Has your child received the following evaluations?

Speech? ☐ NO ☐ YES

Physical? ☐ NO ☐ YES

Occupational? ☐ NO ☐ YES

Developmental? ☐ NO ☐ YES

If yes, what facility/therapist did the evaluation/s and what was the date of the evaluation/s?

_____

6. CHILD'S GROWTH AND DEVELOPMENT

What are your biggest developmental concerns for your child? (ex. Walking, speech, social interaction, behavior, feeding, sensory, etc.) Why do you want him/her to come to Kidspiration?

Milestones: Please put the age your child mastered the following milestones. If they have not yet achieved something, please put an X:

Milestone:	Age Mastered:
Rolled Over	
Sat Independently	
Crawled	
Pulled to Stand	
Walked	
Weaned from Bottle	
Finger Feed	
Potty Trained	

7. LANGUAGE AND HEARING

How well do you feel your child hears? SELECT ONE

Does your child have a history of ear infections? ☐ NO ☐ YES

Has your child had P.E. tubes placed in his/her ears? ☐ NO ☐ YES Date: _____

How does your child mostly communicate:

☐ Gestures/Pointing ☐ Crying ☐ Sentences ☐ Words

If your child primarily communicates by gestures/pointing please answer the following questions:

a. Does your child try to talk in combination with pointing? _____

b. Does anyone in the family talk for your child or interpret his/her gestures? _____

When did your child say his/her first real word? _____

What was his/her first word? _____

When did your child first put two or three words together? _____

When did your child begin to use more complete sentences? _____

Approximately how many different words is your child saying now? _____

Do you consider your child to be talkative or quiet? _____

Did your child's speech/language development seem to stop for some time? ☐ NO ☐ YES

If you answer "yes" to this question, please respond to a. and b. below.

a. When and why do you think it stopped?
_____

b. How did your child communicate with you during this time?
_____

Do you think your child's speech is normal for his/her age? ☐ NO ☐ YES

IF you answer "no" to this question, please respond to a, b, and c below.

a. **Do you have trouble understanding your child's speech?** ☐ NO ☐ YES

b. **Do people outside the family have trouble understanding your child's speech?** ☐ NO ☐ YES

c. **Does your child get frustrated if he/she is not understood by others?** ☐ NO ☐ YES

Do you have any concerns about the way your child's tongue or mouth works for speech or for eating? ☐ NO ☐ YES

If "yes" to this question, please describe: _____

Does anyone in the family have a history of any speech or language problems? ☐ NO ☐ YES

☐ Sibling ☐ Mom ☐ Dad ☐ Grandparent ☐ Aunt/Uncle ☐ Cousin

8. FEEDING

For his/her age is your child: SELECT ONE

Has your child had frequent or severe problems with:

☐ Feeding ☐ Chewing ☐ Teeth ☐ Swallowing

When eating does your child: ☐ Gag ☐ Throw-up ☐ Spit-out ☐ Refuse

Is your child a picky eater? ☐ NO ☐ YES

What are your child's favorite foods and snacks?

_____

9. Social/Emotional/Self-Help

How does your child interact with other children? SELECT ONE

How does your child interact with adults? SELECT ONE

Does your child have trouble separating from you? ☐ NO ☐ YES

Is your child overly sensitive to:

☐ Lights ☐ Sounds ☐ Touch ☐ Smells ☐ Food Textures ☐ Clothing ☐ Textures

Does your child dislike being touched or held? ☐ NO ☐ YES

Does your child avoid eye contact? ☐ NO ☐ YES

Does your child pinch, bite, or hurt self or others? ☐ NO ☐ YES

Do you think your child has a behavioral problem? ☐ NO ☐ YES

If YES, describe behavioral problem:

_____

Methods of Discipline: ☐ Time-Out ☐ Spanking ☐ Positive Reinforcement

☐ Redirection ☐ Yelling ☐ Ignoring ☐ None

Other: _____

Do parents agree on methods of discipline? ☐ NO ☐ YES

Is anyone else (ex. School, sitter, grandparent) having problems with your child's behavior?

☐ NO ☐ YES

Does your child understand common dangers? (ex. stove, roads, heights) ☐ NO ☐ YES

Can your child dress him/herself? ☐ NO ☐ YES

Can your child UNdress him/herself? ☐ NO ☐ YES

Is your child potty trained? ☐ NO ☐ YES ☐ Partially

Does your child let you know when they need to go potty? ☐ NO ☐ YES

Can your child feed him/herself with a spoon/fork? ☐ NO ☐ YES

Will your child stay seated at the table to eat? ☐ NO ☐ YES

10. FAMILY HISTORY

Does anyone in the family (parent or child) have a history of:

physical or sexual abuse? ☐ NO ☐ YES _____

Drug use? ☐ NO ☐ YES _____

Alcohol abuse? ☐ NO ☐ YES _____

Has your child ever been in foster care? ☐ NO ☐ YES When? _____

Note below if any of the child's relatives have had any of the following conditions or diagnosis (for example: brother, aunt, etc.)

Autism: _____

ADHD: _____

Seizures: _____

Hearing Loss: _____

Severe Visual Impairment_____

Birth Defects: _____

Genetic Disorders: _____

Intellectual Disability: _____

Mental Health Problems: _____

School Difficulties/Special Ed: _____

Other: _____

Please list any additional information about your child that might be helpful for our therapists, teachers, and staff to know:

_____ _____

Completed By **Date Completed**

PATIENT INSURANCE INFORMATION FORM

(Please bring a copy of your insurance card with you)

Name of Insurance Company: _____

Address: _____

City/Street/Zip: _____

Insurance Co. Phone Number: _____

Patient Relationship to Subscriber: _____

Subscriber's Social Security #: _____

Subscriber's Full Name: _____

Subscriber's DOB: _____

Subscriber's Address: _____

City/Street/Zip: _____

Subscriber's Phone Number: _____

Subscriber's Employer Name: _____

ID/Policy #: _____Group #: _____ Co-Pay Amount: $_____

Name of Secondary Insurance (if applicable): _____

Subscriber's Name: _____

Group #: _____ Policy # _____

Guarantor (Person Responsible for Payment): _____

If different than Patient or Subscriber, please provide information below.

Patient Relationship to Guarantor: _____

Guarantor's Social Security #: _____

Guarantor's Full Name: _____

Guarantor's DOB: _____

Guarantor's Address: _____

City/Street/Zip: _____

Guarantor's Phone Number: _____

Guarantor's Employer Name: _____

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Outpatient Attendance Policy

Please contact our office at 870-424-4021 if your child is unable to attend his regularly scheduled therapy appointment. Cancelled appointment notifications must be made 24 hours in advance or before 7:00am on the day of the scheduled appointment, with an exception of emergencies and unforeseen illnesses. All requests for changes in your child's therapy schedule will need to be discussed with your child's therapist.

The following definitions and procedures apply to all attendance topics

No Shows

Definition: A no show is any missed appointment without a phone call to cancel the appointment(s) a minimum of 24 hours in advance or before 7:00am on the day of the scheduled appointment.

Procedure: No shows are appointments that are not made up and/or re-scheduled. They are missed appointments. After three no show appointments, your child will be taken off of the therapy schedule and placed on a waiting list.

Cancellations:

Definition: A cancellation is any appointment cancelled by phone or in person 24 hours in advance or before 7:00am on the day of the scheduled appointment. An appointment that is rescheduled does NOT count as a cancellation

Procedure: If your child's attendance rate falls below 75%, there is a possibility that your child's therapy time may be offered to another child on our waiting list. Families who are planning to be absent for greater than 2 weeks will be removed from their treatment schedule, unless previously arranged with your therapist. It is our policy that if you fail to cancel a scheduled appointment within the designated time frame, you will be charged a $25.00 fee for the missed appointment. If your child misses more than one therapy, you will be charged this fee for each hour.

Please note: Therapists are only paid when child is present. Due to limited scheduling availability, we ask that all patients attend their scheduled treatments. When an appointment is applied to our schedule, that time is reserved to meet your child's needs. We work hard to accommodate each of our patients. Continuous neglect to follow the regulations stated in this policy could lead to termination and/or change of status to your remaining treatments and/or sessions. Thank you in advance for your understanding and cooperation in this matter.

Late Arrivals/Pick-ups

Definition: A late arrival occurs any time the child is 5 minutes or later for their scheduled appointment. If the appointment is scheduled for 3 p.m., and you arrive at 3:05 p.m., you are considered late. It is also necessary that you pick your child up on time, as to not interfere with another child's therapy appointment.

Procedure: If your arrival or availability time is 10 minutes or more after your scheduled appointment time, your therapist may have been reassigned to another child's care and your appointment may be cancelled. If you are unsure about whether you can arrive or be available within this time frame, call the clinic and/or therapist to inform them you are running late. Your therapist will determine whether you should reschedule the appointment. A consistent pattern of late arrivals and/or pick-ups will result in a review of your services and possible cancellation of services from Kidspiration. We feel the allotted time for your child's treatment is necessary for adequate rehabilitation of their condition.

_____ _____

Parent/Guardian Signature Date

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CONSENT FOR BILLING

We are pleased to be able to provide services to your child. Because there are so many children who need our services and money is limited, we are required to make use of all possible sources of funding to meet the needs of children. The first source of funding is your family's private health insurance/HMO and/or Medicaid first, then we are unable to seek funding from other sources. If you decline billing of your family's private health insurance/HMO and/or Medicaid, you may be responsible for the entire cost of your child's therapy.

Access of your private health insurance/HMO benefits by Kidspiration should not pose a realistic threat that you or your child will suffer a loss of insurance/HMO benefits. Access of your insurance/HMO will only be done with your approval. The patient shall be financially responsible for any portion of the invoice that is not paid, except in the event of covered services provided to Medicaid recipients. The undersigned agree to execute any and all documents and perform any acts the Kidspiration may reasonably request to ensure that all third-party benefits for therapy services are paid.

Your voluntary permission is required for Kidspiration to submit a claim to your insurance/HMO carrier, please check the appropriate box below and sign this form. With your signature, you authorize direct payment of medical benefits to Kidspiration and that you understand that you are personally responsible to Kidspiration for charges not covered or paid for by your insurance/HMO.

We are required to bill Medicaid for services provided to Medicaid recipients. We do not need permission to do so.

Please check all the apply:

- ☐ I give my permission for Kidspiration to bill my private insurance/HMO for services provided to my child by the program. I hereby agree to pay co-pays and deductible. (If co-pays and deductibles are a financial hardship, please see the office manager for assistance). I also authorize release of medical information necessary to process this claim.
- ☐ I have Medicaid coverage for my child.
- ☐ I do not have any form of insurance coverage or Medicaid.
- ☐ I have private insurance/HMO coverage, but I DO NOT want Kidspiration to bill my private insurance company or HMO and understand that I may be responsible for the cost of my child's therapies.

Signature: _____ Date: _____

Please make sure we receive a copy of your insurance card and/or ID upon arrival at your first visit. Kidspiration will file claims with up to two insurances on your behalf; you will be responsible for filing any additional claims. We will verify your insurance coverage before your initial evaluation and inform you of your child's benefits at your first visit. This is not a guarantee of benefits. If you have an insurance co-payment it will be collected when you sign-in at each visit.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

If you have any questions about this notice, please contact Kidspiration at (870) 424-4021

Kidspiration is required by law to maintain the privacy of your child's health and education information to provide you with a notice of our legal duties and privacy practices, and to follow the information practices that are described in this notice. Kidspiration respects your privacy. We understand that your child/family's personal information is very sensitive. For example, your child's personal information includes demographics, treatment plans, documentation of diagnosis, and treatment records. By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Kidspiration. Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notices of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site or contacting us directly.

I acknowledge receipt of the Notices of Privacy Practices of Kidspiration

_____ _____

Parent/Guardian Signature Date

Kidspiration

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POLICY FOR INSURANCE PARTICIPANTS

We are filing your insurance through a contracted plan. It is your responsibility to provide us with the correct insurance information and include a current identification card BEFORE SERVICES ARE RENDERED. Should you not have your insurance card with you at the time of your appointment, you will be required to either pay in full for services performed or reschedule your appointment so that you may obtain the insurance card.

It is also your responsibility to provide your insurance company with a completed "Coordination of Benefits" form at the beginning of each calendar/benefit year. You may obtain this form from your insurance company.

DEDUCTIBLES AND CO-PAYMENTS WILL BE COLLECTED AT THE TIME OF SERVICE. WE WILL BILL YOUR INSURANCE COMPANY FOR THE BALANCE UNDER THE PLAN PROVISIONS. WE HONOR ALL OF OUR INSURANCE CONTRACTS AND TAKE ADJUSTMENTS AS INSTRUCTED BY OUR PAYORS. AFTER YOUR INSURANCE PAYS AND REQUIRED ADJUSTMENTS ARE APPLIED, YOU WILL RECEIVE A STATEMENTS FOR ANY REMAINING BALANCE THAT IS YOUR RESPONSIBILITY PER YOUR INSURANCE PLAN. PROMPT PAYMENT IS EXPECTATED AND APPRECIATED AND MUST BE RECEIVED PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS

It is your responsibility to follow up with your insurance company to be sure that all of your claims have been processed and paid to us for services performed.

By signing below

- I understand and agree to the above stated policy
- I understand that I am responsible for my co-payment and/or deductible at the time services are performed if applicable.
- I understand that at each visit I am to inform this office of any changes of insurance, addresses, phone numbers, etc. If I do not, and the insurance is filed incorrectly as a result, I understand that I am responsible for the charges incurred.
- I grant permission for Kidspiration to collect payment due from my insurance company for services performed.

_____ _____

Parent/Guardian Signature Date