KIDZ KORNER

The Pediatric Therapy SPOT

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Fort Walton Beach, Fl. 32548
Fax: 850-200-4350
Phone: 850-200-4348

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Phone: 850-353-2415
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www.KidzKornerspot.com

Welcome Letter

Welcome to Kidz Korner! We are happy that you and your child will be receiving services with us. Please fill out the enclosed paperwork and bring it to the initial evaluation. It is very important that you fill out this paperwork and return it in a timely fashion so that we can plan the best treatment for your child. Please use this checklist to help you remember to fill out the important papers.

- Registration Form—Please include your cell phone number if this is where we can best reach you. Thank you!
- Intake Questionnaire
- Contract for Services
- Cancellation Policy
- Authorization for exchange of information

Please feel free to visit our website www.KidzKornerspot.com to find out more information about our clinic. We are looking forward to meeting you and your child!

Michelle Horin MHS,OTR/L
Director's Signature

Dear Parents,

First, I want to say thank you so much for giving us the opportunity to serve your family here at KIDZ KORNER. We appreciate being able to care for your families and to help your child's development in every way. This letter contains some housekeeping items related to billing and the financial piece of your child being a part of KIDZ KORNER. While the financial piece of KIDZ KORNER is not a favorite topic to discuss, it is one of necessity in order to maintain the level of excellence at our clinic in regards to equipment and training for our amazing therapists and staff.

You will see on our invoices beginning January 1, 2017 that the rate of reimbursement for services is as follows

OT/PT/ST EVALUATION or RE_EVALUATION - $200
OT/PT/ST 15 MINUTES - $35
OT/PT/ST 30 MINUTES - $70
OT/PT/ST 45 MINUTES - $105
OT/PT/ST 1 hour treatment session - $140

For caregivers who have to pay out of pocket, we like to help in any way we can. We will give parents who have to pay out of pocket a **15% discount** for 1 hour PT/OT treatment sessions reducing the **out of pocket rate to $119**.

- We give a **15% discount FOR OT/PT TREATMENT SESSIONS WHEN THE <u>FULL</u> PAYMENT IS RECEIVED <u>within 30 days of the monthly invoice</u>. NO EXCEPTIONS!!**
- **After the 30-day period** has passed the discount is taken away and the caregiver will owe the full therapy amount of **$140** per 1-hour treatment session and/or the amount of your co-payment/cost share**.**
- **After the 60-day period a 15% additional LATE fee** will be added to the **initial** invoice.
- **After the 90-day period you will be turned over to a collection agency and taken off of the therapy schedule.**

I apologize for any inconveniences and appreciate your understanding in regards to these changes. Please do not hesitate to contact me directly with any questions that you may have.

Michelle Horin, MHS, OTR/L
OWNER KIDZ KORNER

Registration Form

(Please Print)

Today's date:			Parent/Guardian:		
PATIENT INFORMATION					
Patient's last name: First: Middle:			Birth date: / /		
Street address:	P.O. box:	Social Security no.:	Home phone no.: ( ) -	Age:	Sex: ❑ M ❑ F
City:		State:		ZIP Code:	
EMAIL ADDRESS: (We need two emails on file) 1. 2.		Phone number where to best reach you: Mom Cell: Dad Cell: Other:			

INSURANCE INFORMATION				
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No				
Please indicate primary insurance	❑ Tricare Prime	❑ Tricare Standard	❑ Private Pay	
Subscriber's name:	Subscriber's S.S. no.:		Birth date: / /	Co-payment: $
Type of Insurance:	Policy #:		Group #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kidz Korner The Pediatric Therapy SPOT to release any information required to process my claims.

Patient/Guardian signature *Date*

Occupational Therapy Intake Questionnaire

Physician/Physicians following your child:_____

Reason for
referral:_____
_____
_____
_____

When were these problem first noticed? _____

What are your greatest concerns?
_____
_____
_____
_____
_____

PERINATAL & BIRTH HISTORY:

Was the pregnancy complicated? **YES/NO**

Method of delivery: _____vaginal _____caesarian _____ forceps used _____ breech

Was birth premature? **YES/NO** Gestational age at birth? _____

Did child require oxygen? **YES/NO**

Did child require feeding tube? **YES/NO**

How long was child hospitalized at birth? _____

Has your child seen a neurologist? **YES/NO** If yes, who/when? _____

Has your child had an MRI/CT scan? **YES/NO** Results: _____

MEDICAL HISTORY:

Allergies including food/latex _____

Medical history _____

Hydrocephalus/shunt _____

Seizures (appearance, type, response needed) _____

Ear Infections _____ Ear tubes _____

Vision problems **YES/NO** Explain: _____

Surgeries/Other:_____

Please list any medications your child is currently taking _____
_____

Last time hearing was tested_____ Results?_____

If your child is 0-3, are they receiving Early Intervention Services? **YES/NO**

If **yes,** which services? ____Developmental Therapist (ITDS) ____ Physical therapist

____ Occupational therapist ____ Speech therapist

ACADEMICS:
Where does your child go to school? _____

What grade level are they currently attending? _____

Please check all that apply regarding your child's educational setting:

_____ Full time regular classroom

_____ Full time special education classroom

_____ Resource room pull out

Does your child have a current IEP? **YES/NO** (if **yes**, please provide a copy)

Is your child receiving services in the school system? **YES/NO**

Which services? ____ Physical therapy ____ Occupational therapy ____ Speech therapy

How often? _____

If any, what concerns do **you** have in regards to your child's independence in the school environment? Please include all that apply: physical, behavioral, attention or academic performance.

_____
_____
_____

If different, what concerns have the **teacher(s)** raised?

_____
_____
_____

Is your child receiving other OUT PATIENT services? YES/NO

Service	Frequency/Location
☐ Physical Therapy	☐ _____
☐ Speech Therapy	☐ _____
☐ ABA	☐ _____
☐ Psychological	☐
☐ Other	☐ _____

BEHAVIORAL:

If your child has difficulty in any of the following areas: Please explain

- Communicating needs and wants

  _____
  _____
  _____
  _____

- Transitioning from one environment/activity to another?

  _____
  _____
  _____
  _____

- Self-Stimming and/or any peculiar behaviors i.e. flapping his hands, spinning, etc?

  _____
  _____
  _____
  _____

- Frequent, significant tantrums - If yes, what triggers the tantrums?

  _____
  _____
  _____
  _____

- Attention within school and home environments

  _____
  _____
  _____
  _____

SENSORY:

Are you aware of or concerned about any sensory behaviors that your child engages in and /or avoids? (touch, movement, auditory, visual, proprioception, oral)

_____
_____
_____
_____

Functional Skills

GROSS MOTOR:

Describe your child's gross motor skills (Can he walk, run, throw and catch a ball, ride a trike/bike with or without training wheels) :

_____
_____
_____
_____

Is your child involved in any sports/physical activities such as soccer, T-ball, baseball, swimming, horseback riding, creative movement, etc. ?

_____
_____
_____
_____

Any current concerns:

_____
_____
_____
_____

FINE MOTOR:

Is your child **INDEPENDENT** with the following tools? ___writing utensil ___fork ____ spoon ____knife ___ scissors

Describe any concerns regarding the above tool use

_____
_____
_____
_____

SELF-CARE SKILLS:

- Can your child independently **PUT ON** the following clothing items:

_____ shirt _____ pants _____ underwear _____ socks _____ shoes

- Can your child independently **TAKE OFF** the following clothing items:

_____ shirt _____ pants _____ underwear _____ socks _____ shoes

- Please check if your child is **independent** with the following fasteners:

_____ zippers _____ buttons _____ snaps _____ shoe tying

- Please check if your child is **independent** with the following self care skills:

_____ toileting _____ bathing _____ teeth brushing

Describe any concerns regarding avoidance, sensitivity and/or tolerance during the above self care skills

_____
_____
_____
_____

Does your child have a limited or picky diet? **YES/NO**

If yes, please provide a list of your child's preferred and no-preferred foods:

Preferred Foods	
Non-preferred foods (i.e. ones that may cause gagging or severe negative responses)	

PLAY SKILLS:

Describe the play activities that your child engages in:

_____
_____
_____

What concerns, if any do you have regarding your child's play or socialization skills?

_____
_____
_____

OTHER:

Please list any other concerns you have about your child that have not yet been addressed:

_____
_____
_____
_____
_____

What new skills would you like for us to work toward while your child is at Kidz Korner?

_____
_____
_____
_____

Speech Intake Questionnaire

Physician/Physicians following your child:_____

Reason for
referral:_____
_____
_____

When were these problem first noticed? _____

What are your greatest concerns?

_____

_____

_____

PERINATAL & BIRTH HISTORY

Was the pregnancy complicated? YES/NO

Method of delivery: vaginal _____caesarian_____ forceps used_____ breech_____

Was birth premature? YES/NO Gestational age at birth? _____

Did child require oxygen? YES/NO

Did child require feeding tube? YES/NO

How long was child hospitalized at birth? _____

Has your child seen a neurologist? YES/NO If yes, who/when? _____

Has your child had an MRI/CT scan? YES/NO Results: _____

MEDICAL HISTORY

Allergies including food/latex _____

Medical history _____

Hydrocephalus/shunt _____

Seizures (appearance, type, response needed) _____

Ear Infections _____ Ear tubes _____

Vision problems YES/NO Explain: _____

Hearing problems YES/NO Explain: _____

Surgeries/Other:_____

Please list any medications your child is currently taking _____

_____

Last time hearing was tested_____ Results?_____

Academics:
Is your child attending a preschool or elementary school? YES/NO

If yes, please list school name _____

Please circle all that apply regarding your child's educational setting:

- Full time regular classroom
- Full time special education classroom
- Resource room pull out

Does your child have a current IEP? YES/NO (if yes, please provide a copy)

Resource room?

If any, what concerns do **you** have in regards to your child's independence in the school environment? Please include physical, behavioral, attention or academic performance.

_____

_____

_____

If different, what concerns have the **teacher(s)** raised?

_____

_____

_____

Is your child receiving other outpatient services? YES/NO

Service	Frequency/Location
☐ Physical Therapy	☐ _____
☐ Occupational Therapy	☐ _____
☐ ABA	☐ _____
☐ Psychological Services	☐ _____
☐ Other	☐ _____

Speech/Language/Hearing Skills

HISTORY

Has your child ever had a speech and language evaluation or screening? YES/NO
If YES, what were the findings:

_____
_____
_____

Do you feel your child has Speech and Language difficulties? YES/NO
Please Explain:

_____
_____
_____

What is your child's primary language? _____

Are there any other languages spoken in the home? YES/NO
If YES, please list other languages: _____

ORAL MOTOR HABITS

Was your child:

- Breast fed
- Bottle Fed
- Combination

Does your child use:

- Pacifier
- Suck his/her thumb

If yes, how often: _____

Would you describe your child as a "mouth breather"? YES/NO

Do you notice excessive drooling? YES/NO

Do you notice excessive mouthing of toys? YES/NO

LANGUAGE SKILLS

Please estimate how many words are in your child's vocabulary (please check below):

RECEPTIVE LANGUAGE (How many words he/she understands)

- 0-25
- 25-50
- 50-75
- 75-100
- >100

EXPRESSIVE LANGUAGE (How many words he/she can say)

- 0-25
- 25-50
- 50-75
- 75-100
- >100

What percentage of your child's speech do **YOU** understand:

- 10% or less
- 11-24%
- 25-50%
- 51-74%
- 75-100%

What percentage of your child's speech do **OTHERS** understand:

- 10% or less
- 11-24%
- 25-50%
- 51-74%
- 75-100%

Does your child demonstrate frustration when he/she is not understood? YES/NO

Please explain:

_____
_____
_____

COMMUNICATION SKILLS

Currently does your child:

- Respond to his/her name? YES/NO
- Point to objects when asked? YES/NO
- Follow simple directions? YES/NO
- Get objects from another room when asked? YES/NO
- Point to body parts when asked? YES/NO
- Answer simple questions? YES/NO
- Point to family members when asked? YES NO
- Understands prepositions (over, under, in, out)? YES/NO
- Understand colors and sizes? YES/NO
- Engage in imaginary/pretend play? YES/NO
- Does your child play/socialize with other children? YES/NO

What is your child's primary mode of communication (please check all that apply):

- Gestures
- Sign language
- Grunts
- Screams
- Single words
- 2-3 word combinations
- Short 3-4 word phrases
- Sentences with some errors

- Grammatically correct sentences
- Tell stories and explains what happens
- Augmentative Communication
- Copies what you say
- Stutters
- Speaks too soft
- Speaks too loud

RESONANCE/VOICE/STUTTERING

RESONANCE:

Does your child sound like he/she has a cold when they are talking? YES/NO

Has your child been evaluated by an ENT physician? YES/NO

Do you have concerns related to your child's voice quality (i.e. Speaking too soft, breathy, hoarse, strained or too loud)? YES/NO

STUTTERING/FLUENCY:

Describe your child's pattern of stuttering:

_____

_____

_____

When did the stuttering begin? _____

Has anything helped to decrease your child's stuttering in the past? YES/NO

Please explain:

_____

_____

_____

BEHAVIORAL:

Does your child have difficulty socializing at school or in any other environment? YES/NO

Does s/he transition well from one environment/activity to another? YES/NO

Does s/he exhibit any peculiar behaviors i.e. flapping his hands, spinning, etc.? YES/NO
If yes, explain

_____

_____

_____

Does your child have frequent, significant tantrums? YES/NO
If yes, what triggers the tantrums?

_____
_____
_____

FEEDING:

Please mark any that you have observed with your child:

- Puts too much food in at one time
- Unable to drink without spilling
- Food falls out of their mouth
- Coughing or choking on certain foods:
    - Please list: _____
    - _____
    - _____
    - _____
- Avoiding certain textures:
    - Please list: _____
    - _____
    - _____
    - _____
- Please describe your typical meal:
  _____
  _____
  _____

What type of cup does your child drink from? _____

Other:
Please list any other concerns you have about your child that have not yet been addressed:

_____
_____
_____
_____
_____

What new skills would you like for us to work toward while your child is at Kidz Korner?

_____
_____
_____
_____

AVAILABILITY:

Please tell us the times and days that your child is available for therapy. We will do our best to meet those needs, but please understand that we have numerous children to accommodate so please be as flexible as possible.

PARENTS/CAREGIVERS: Thank you so much for taking the time to fill out this information so we can best help your child. We are looking forward to meeting you and your family!!!!

Sincerely,

KIDZ KORNER STAFF

Contract for Occupational And Speech Therapy Services

Child's Name: _____

I understand that *Kidz Korner The Pediatric Therapy SPOT* does not verify insurance eligibility or benefits. I am responsible to confirm that *Kidz Korner The Pediatric Therapy SPOT* is a contracted provider with my specific insurance plan and to verify the benefits allowed for OT services.

I understand that I am responsible to obtain physician referrals and insurance authorizations, to keep track of the number of visits used relative to those authorized, the expiration date of the authorization and/or the contract limitations (dollar amount). If progress reports and/or treatment plans are required by a physician or insurance company, I will notify the therapist at least one month before they are due to allow time for completion of the paperwork. If insurance is billed by *Kidz Korner The Pediatric Therapy SPOT* my insurance company may request information regarding treatment and I give my consent for the release of this information.

I understand that I am responsible for payment of the account and responsible to guarantee that the account is paid on a timely basis – whether payments are made by myself or by my insurance company. If claims are submitted to insurance and payment is not received within 45 days, I agree to follow up with the insurance company regarding payment.

As part of ongoing therapy services the evaluative treatment sessions are billed at $200 per hour and therapy services are billed at $140 per hour.

Insurance waiver

(Signature required by *all insured clients* **– if claims *are or are not* submitted)**

I understand that my insurance company may not consider the OT services that are provided by *Kidz Korner The Pediatric Therapy SPOT* to be a covered medical expense.

I understand that even though OT services are listed as covered medical expenses on my insurance plan – payment for the services provided are not guaranteed. Upon receipt of claims for services received, my insurance company will complete a review for medical necessity and based on that review (related to my child specifically) the services *may* be determined to be *non-covered expenses*.

I elect to have *Kidz Korner The Pediatric Therapy SPOT*. provide OT services for my child. I understand that if my insurance plan does not allow benefits or approve payment of claims for services my child has received, *I am responsible for all incurred charges and I agree to pay the balance in full.*

Insurance waiver

(Signature required by *all insured clients* **– if claims *are or are not* submitted)**

I understand that my insurance company may not consider the OT services that are provided by *Kidz Korner The Pediatric Therapy SPOT* to be a covered medical expense.

I understand that even though OT services are listed as covered medical expenses on my insurance plan – payment for the services provided are not guaranteed. Upon receipt of claims for services received, my insurance company will complete a review for medical necessity and

based on that review (related to my child specifically) the services *may* be determined to be *non-covered expenses*.

I elect to have *Kidz Korner The Pediatric Therapy SPOT* provide OT services for my child. I understand that if my insurance plan does not allow benefits or approve payment of claims for services my child has received, *I am responsible for all incurred charges and I agree to pay the balance in full.*

Cancellation Policy

Our goal at Kidz Korner is to provide high quality therapeutic care to our client's and their families. We value your time, our time and the services we provide. When you make an appointment at Kidz Korner for OT, PT or ST that time is reserved exclusively for you. We schedule our resources and staff to that appointment time for your family. We do understand that there are times when you will have to miss an appointment due to emergencies or obligations for family or work. Please understand, cancellations without notice cost our facility and staff financially and prevents other children from being seen. This is why a cancellation of an appointment requires notice by either party. YOU CAN CANCEL OR CHANGE YOUR APPOINTMENT without incurring any fees, as long as you give a 24-HOUR notice. You may call 850.200.4348 or email kidzkornerot@gmail.com to leave a message in regard to cancellations.

We do expect a 75% attendance rate for all therapy sessions. If we notice less than 75% attendance rate within a 3 month period, you will receive a warning. If attendance continues to be less than 75%, you will be removed from the weekly schedule and placed on a wait list.

A SHORT-NOTICE cancellation or failure to attend or be present for an appointment that is less than a 24-HOUR notice, will result in the generation of a cancellation fee in line with our cancellation policy. This fee may be waived at the discretion of Kidz Korner Management. If you feel like your circumstances require special consideration, please let us know.

CANCELLATION POLICY:

1. **Failure to Show for your appointment:**
    a. not showing up for your appointment with NO phone call at all, regardless of the circumstances will result in a $25 missed appointment fee. This fee MUST be paid prior to the next appointment.
    b. After 3, NO-SHOW appointments you will forfeit your weekly scheduled appointment, and will go onto a waiting list.

2. **Cancellation of appointment with less than 24-hour notice:**
    a. A 24-HOUR notice is required for cancellation of your child's appointment with Kidz Korner.
    b. Failure to provide less than a 24-hour notice will result in a $25 cancellation fee generation. This fee must be paid prior to the next appointment.
    c. 3 cancellations in a row will result in your child being removed from their regularly scheduled appointment and placed on the waiting list.

3. **Unplanned Cancellations:**
    a. These include illness, weather, family emergency, traffic/accident or other last-minute mishaps. Please call the office as soon as you are aware of the situation.
    b. We understand and will work with unplanned cancellations, however, more than 3 unplanned cancellations per calendar year will be allowed by Kidz Korner. After more than 3 unplanned cancellations are incurred, a $25 fee will be administered to your account that must be paid prior to your next appointment.

Late Pick Up Policy

If you are late picking up your child from an appointment, you are causing another child not to receive their full billable treatment time and affect our therapist's ability to bill and get paid. If you are late two (2) times picking up your child, you will be asked to not leave the premises during their session.

Treatment Room Policy

We have been so fortunate to see such a growth in the number of families that need our help. Due to this growth as well as the privacy laws regarding HIPPA, parents/siblings will no longer be able to go back for OT/PT sessions with their child on a regular basis. Please DO NOT misinterpret that you are NEVER allowed to go back. We ask that you discuss coming back into the treatment areas with your treating therapist so they can reserve a room for the session. Due to space issues, it is possible that another parent will be in the same clinic space at the same time as your child. We will do our best to insure privacy with treatment sessions if this does occur.

Sick/Illness Policy

This facility is a **well-child** facility. This means that if your child is not feeling well, for any reason, you will need to reschedule your therapy appointment.

Please do not bring your child if he/she has a contagious illness or exhibits any of the following symptoms within **the last 24 hours**:

- Fever above 100 degrees Fahrenheit
- Vomiting, in excess of typical infant spit-ups
- Diarrhea
- Conjunctivitis ("pink eye")
- Consistent complaints of ear or stomach pain
- Bleeding other than minor cuts and scrapes

- Greenish nasal discharge, indicating possible infection
- Head lice

***If your child or anyone in your family is having any of the above symptoms AND has been EXPOSED to someone who has tested positive for COVID, please call our clinic and cancel any appointments your child has within 5 days of positive test/exposure. If your child is clear to go to school after exposure, they are clear to come to therapy following any of the recommendations that are in place by the school. If your child tests positive, once they are clear to return to school, they are clear to come to the clinic. Please verify with our front desk office how long it is recommended for your child to stay home so that we cancel/reschedule appropriately. If you are home due to exposure or a positive test, teletherapy will be offered to ensure continuation of care.**

*********In general, if your child is too sick to go outside and play OR go to school, then your child is too sick to attend therapy.*********

Notice of Privacy Practice (HIPAA)

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

We are permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

- For Treatment- We may share with your physician copies of your treatment plan or evaluation to update him/her on your progress or for his/her approval or recommendations.
- For payment- We may send information to your health insurance plan for them to review and determine level of coverage for therapy services.
- For health care operations- We may access your health information for purposes of quality improvement within our facility.

1. We are permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.
2. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
3. We intend to engage in one or more of the following activities:
   - We may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
   - A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
   - The individual has the following rights regarding protected health information:
   - The right to request restrictions on certain uses and disclosures of protected health information. We are not required to agree to a requested restriction, however.
   - The right to receive confidential communications of protected health information, as applicable.
   - The right to inspect and copy protected health information, as provided in the privacy regulation.
   - The right to amend protected health information, as provided in the Privacy Regulation.
   - The right to receive an accounting of disclosures of protected health information.
   - The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
4. We are required by law to maintain the privacy of protected health information and provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
5. We are required to abide by the terms of Notice currently in effect.
6. We reserve the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
7. We will provide individuals or patients with a revised notice by posting a notice in a central location in the waiting area.
8. We are not permitted to associate with current patient or their families on social media per HIPPA regulations.

Kidz Korner Policies Agreement

1. I have read and understand the office policies. I agree to be bound by the fee structure and cancellation penalties.

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

2. Signature below indicates acknowledgement of sick/illness policy, cancellation policy, and late pickup policy and agree to adhere to these policies.

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

3. I have read and understand the HIPAA privacy policies.

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

4. I have read and understand the liability disclaimer.

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

5. I have read and understand the Contract for Occupational/Physical Therapy Services.

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

6. I have read and understand the Insurance Waiver.

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

7. I have read and understand the Treatment Room Policy.

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

Authorization for Information Exchange

Child's Name _____

Date _____

Child's Date of Birth_____

I hereby authorize *Kidz Korner The Pediatric Therapy SPOT* to give and/or receive in verbal, written, or video form information pertaining to the above named child.

I authorize exchange of information between *Kidz Korner The Pediatric Therapy SPOT* and the party or parties listed below:

Name	Address	Phone

A photocopy of this document shall be considered to be as valid as the original. This authorization for release of information shall remain in effect until revoked and may be revoked by myself at any time by giving a written notice to *Kidz Korner The Pediatric Therapy SPOT*.

I understand that the information obtained will be treated in a confidential manner and will not be given to a third party without my permission unless required by law.

Parent/guardian signature: _____ **Date:** _____

Permission to Pick up from Therapy

I _____ (Parent/Guardian) of

_____ (Child's Name) authorize the following people

to pick-up my child from Therapy at Kidz Korner.

Name	Phone #	Relationship
1.		
2.		
3.		
4.		
5.		

_____ _____

Parent/Guardian Signature Date

Video/Photography Release

Parent and/or Guardian consent for Videotaping/Photographing of Evaluation and/or Treatment Session(s). Your signature below indicates that you consent to your child being video/audio recorded or photographed during evaluations and/or treatment sessions for the purposes of **diagnosis**, **reference**, **education**, and **training**. Photos and videos ***will not*** be posted to the internet/website nor social media outlets.

I do give Kidz Korner permission to videotape or photograph my child.

Signature of Legal Guardian: _____
Date: _____

I do NOT give Kidz Korner permission to videotape or photograph my child.

Signature of Legal Guardian: _____
Date: _____

School IEP Disclosure

Is your child receiving therapy services in the school?

YES: _____ (please provide a copy of your child's IEP to ensure there is no duplication of services)

NO:_____ (Please sign below)

To: Tricare Referral Management

From: Mr./Mrs. _____

Date: _____

Re: OT services for my child _____

To Whom It May Concern,

My child is currently not receiving any therapy (OT,PT or ST) services at school or privately besides at Kidz Korner The Pediatric Therapy SPOT. Thank you for your help with this matter.

Sincerely,

_____

Release of Liability/Authorization for Treatment

I, _____, acknowledge and agree to have my child, _____, participate in therapy services at KIDZ KORNER. I acknowledge that there is some risk inherent in the use of therapy equipment. I hereby release KIDZ KORNER, its principle owners, therapists, employees, representatives and all other individuals or organizations acting on its behalf in connection with this program from any and all claims which I or my child may have arising from, resulting from, or in connection with my child's participation in therapy including, but not limited to, injuries resulting from the use of play equipment during the program. The foregoing shall exclude any grossly negligent or willful or wanton acts or omissions by KIDZ KORNER. This release shall be binding upon and shall ensure to the benefit of the parties and their respective heirs, executors, legal representatives, and successors. This agreement is signed for the purpose of fully and completely releasing and discharging KIDZ KORNER, its principle owners, therapists, employees, representatives and all other individuals or organizations acting on behalf of KIDZ KONRER, in connection with this program from all liability as herein described.

By signing below, I, on behalf of myself, my heirs, agents and/or representatives, hereby waive, release and forever discharge KIDZ KORNER, including without limitation its principle owners, therapists, and employees from any and all liability, damages, claims, demands, and/or causes of action, whether known or unknown, whether now or existing in the future, for any claims for physical injury or disease.

Child's Name_____

_____ _____

Parent/Guardian Signature Date

Kidz Korner Bathroom Policy

Toilet training is an important milestone and self-help skill for children to learn. However, as with any learning experience, this process is developmentally individual to each child. Therefore, we understand that your child may not be potty trained and may require bathroom assistance during their session. If the parent is not present during the session and a toileting need arises, the therapist is responsible for supervising or assisting the child as deemed necessary.
If your child is in the process of toilet training or has frequent accidents, please ensure that they use the restroom prior to their session and have a change of clothes as well as a clean diaper/pull-up available.
In order to help us best be prepared and understand your wishes, please check all that apply:

____ My child is typically independent in the bathroom.

____ My child typically requires assistance in the bathroom.

____ I give permission for my child's therapist to assist my child in the bathroom.

____ I do not give permission for my child's therapist to assist my child in the bathroom.

Please be aware that if you do not wish for your child to be assisted in the bathroom, you should remain in the waiting area during the treatment session.

If we do not have permission to assist your child, an accident occurs, and you are not in the waiting area, your child's session may be discontinued for that date of service. This will allow us to ensure our therapy rooms stay in clean/healthy condition for others.

By signing below, I am in agreement with the above policy and allow my child's therapist to assist them with their toileting needs.

Child's Name_____

_____ _____
Parent/Guardian Signature Date

Release for Appointment Reminders

I, _____ (Print), hereby authorize "KIDZ KORNER" to send me an appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as, but not limited to, patient first name and clinic location.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: _____

Cell phone: _____

Patient / Guardian (Print): _____

Signature: _____

Date: _____