

**INFANT Registration Form**

Date: \_\_\_\_\_

Infant's Name: \_\_\_\_\_ M / F DOB: \_\_\_\_\_

**Primary Guardian's Name(s):** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_  permission to leave a detailed voicemail  
 text message reminderEmail: \_\_\_\_\_  email appointment reminderPreferred language:  English  Spanish  Other \_\_\_\_\_Does child reside with both legal parents in the same household?  Yes  No

-Who has the legal right to make medical decisions for child? \_\_\_\_\_

**Secondary Guardian's Name (if applicable):** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_  permission to leave a detailed voicemail  
 text message reminderEmail: \_\_\_\_\_  email appointment reminder**Pediatrician:** \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Primary Insurance:  
\_\_\_\_\_Secondary Insurance (if applicable):  
\_\_\_\_\_

Who referred you? \_\_\_\_\_

Allergies: \_\_\_\_\_

## Attendance and Cancellation Policy

We want your child to achieve his or her greatest potential and receive maximum benefit from therapy. Regular attendance and follow through with home program activities are key factors for improving your child's skills.

We expect that your child will attend all scheduled appointments. In the event that you need to cancel, you are required to give **48** hours' notice. If your child has multiple therapies or you have more than one child attending therapy, please be sure to cancel all appointments that will be missed. If your child misses more than two appointments in a two-month period, we reserve the right to take your child off the regular therapy schedule unless make-up sessions were scheduled.

1. **Illness** Please contact the office as soon as possible. You will not be charged but the cancellation will be counted as a missed visit. *Please do not bring any child, sibling, or adult to the clinic if they have had a fever, pink eye, lice, diarrhea and/or vomiting in the past 24 hours. If you or your child has a cold, it is alright to attend therapy if you feel okay **unless** there is fever, hacking or persistent cough, or green or yellow mucus.*
2. **Late Cancellation/No Show** A fee of \$50 will be charged for appointments cancelled less than **48** hours before time of appointment or for a no show for an appointment. This fee is to be paid out-of-pocket, is not covered by insurance, and must be paid within two weeks of the missed appointment.
3. **Weather Cancellations** The clinic will close if Denver Public Schools are closed. These cancelled appointments will not be counted towards missed appointments.

We greatly appreciate your help in making your child's therapy the best that it can be. Our therapists will also follow these policies and will make every effort to notify you of any therapy cancellations or schedule changes as soon as possible. Communication between therapists and parents is critical and we encourage you to keep the conversation going!

## PARENT RIGHTS, ATTENDANCE POLICY, AND CONSENT FOR TREATMENT

As part of every evaluation and treatment received at Amaryllis Therapy Network, you will be treated with respect. You are entitled to information about the techniques used in your child's evaluation and treatment and an estimate of the duration and cost of therapy. You may also ask your therapist about his or her training and credentials. You have the right to seek a second opinion or to end the evaluation or treatment at any time.

In order for your child to receive the maximum benefit from therapy, it is vitally important that he or she attend scheduled appointments on a regular basis and follow the home program activities provided by your child's therapist. Amaryllis Therapy Network has a **48-hour cancellation policy or a \$50 fee** will be charged for the missed visit. This fee is to be paid out-of-pocket, regardless of your insurance coverage. Please see the attached **Attendance and Cancellation Policy** for complete details.

I acknowledge that (***please initial***):

\_\_\_\_\_ I have read the above statements and will adhere to these policies.

\_\_\_\_\_ I have received a copy of the Attendance and Cancellation Policy.

\_\_\_\_\_ I hereby give permission for evaluation and treatment of my child at Amaryllis Therapy Network.

\_\_\_\_\_ I will pay for therapy services at the time of treatment.

\_\_\_\_\_ I give permission for Amaryllis Therapy Network to provide me a written copy of my child's initial evaluation.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent/Guardian's Name (print)

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you and/or your child may be used and disclosed and how you can get access to this information. We have the following duties regarding the maintenance, use and disclosure of you and/or your child's health records to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

- We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
- We are required to abide by the terms of this Notice currently in effect.

### Uses and Disclosure

How we may use and disclose Health Information about you and/or your child:

The following categories describe examples of the way we use and disclose health information.

**Treatment:** We may use health information about you and/or your child to provide treatment or services. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. For example, your protected health information may be disclosed to a home health agency or physician that provides care for you and/or your child.

**Payment:** We may use and disclose health information about the treatment and services to bill and collect payment from you, your insurance company or a third party payer. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and per-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

**Health Care Operations:** Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

**As required by law:** We may use or disclose your health information for the following types of entities without first obtaining your authorization.

- Public Health and Oversight Activities
- Law enforcement
- Legal proceedings
- Communicable Disease Health Oversight
- Abuse or neglect
- Funeral directors, coroners and medical directors
- Food and Drug Administration
- Organ and tissue donation organizations
- Criminal activity
- Military command authorities
- National Security and Intelligence Agencies
- Workers' Compensation

Under law, I must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine my compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent and/or authorization to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your provider, or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Your Health Information Rights

Following is a statement of your rights with respect to your protected health information.

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend:** If you feel that health information we have about you and/or your child is incorrect or incomplete, you may ask us to amend the information. We may deny your request for amendment and if this occurs, you will be notified of the reason for the denial
- **Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or healthcare operations where an authorization was not required.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you and/or your child to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Paper Copy of this notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

### Complaints

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You and/or your child will not be penalized for filing a complaint.** For more information on filing a complaint with the government call 1-866-627-7748 or visit the website at [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/).

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM**

By signing this form, I acknowledge that I have received a copy of Amaryllis Therapy Network, Inc.'s Notice of Privacy Practices.

\_\_\_\_\_  
Child's Name\_\_\_\_\_  
Date of Birth\_\_\_\_\_  
Parent/Guardian's Name (print)\_\_\_\_\_  
Relationship to Child\_\_\_\_\_  
Parent/Guardian's Signature\_\_\_\_\_  
Date

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For office use only:

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Release of Information/Pick-up and Drop-off Consent**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, \_\_\_\_\_ (parent/guardian's name) authorize Amaryllis Therapy Network to:

Release written medical records to Name: \_\_\_\_\_

Exchange verbal information with (Relationship to Child) \_\_\_\_\_

Pick-up/Drop-off Only Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Release written medical records to Name: \_\_\_\_\_

Exchange verbal information with (Relationship to Child) \_\_\_\_\_

Pick-up/Drop-off Only Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Release written medical records to Name: \_\_\_\_\_

Exchange verbal information with (Relationship to Child) \_\_\_\_\_

Pick-up/Drop-off Only Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

**Parent/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## INFANT Registration Form

**Infant's name:**

**Family History**

Please list all household members:

Name _____	Age _____	Relationship _____
Name _____	Age _____	Relationship _____
Name _____	Age _____	Relationship _____
Name _____	Age _____	Relationship _____
Name _____	Age _____	Relationship _____

Do all members live in the same household?  Yes  No

Is there any family history of developmental problems (i.e. sensory, learning, speech, motor, vision)?  Yes  No

If yes, please describe.

**Pregnancy and Birth History**

If your child is adopted, do you have information about the birth mother's health and pregnancy or any inheritable traits? Please share any helpful information.

Were there any difficulties experienced during pregnancy?  Yes  No

If yes, please explain.

Were any medications taken during the pregnancy?  Yes  No

If yes, please name type of medication and reason.

Were fertility drugs used?  Yes  No

Were there any birth complications?  Yes  No

If yes, please explain.

Was the baby carried breech?  Yes  No

Was there an extended stay at the hospital?  Yes  No

If yes, for how long? \_\_\_\_\_

\_\_\_\_ C-section (\_\_\_\_ emergency \_\_\_\_ planned)

\_\_\_\_ Vaginal delivery

Gestational age at delivery \_\_\_\_\_

Birth weight \_\_\_\_\_

Apgar scores (if known) \_\_\_\_\_

Is your baby breast fed or bottle fed (please circle)?  
 Are there any problems with sucking or feeding?  Yes  No  
 If so, please explain.  
 Do you experience pain during breastfeeding?  Yes  No

Has your baby had any medical procedures (i.e. tongue or lip tie release)?

Current medications?  
 Any known allergies?  
 Has your baby received any x-rays or imaging?  Yes  No  
 If yes, what were the results?

At what age did your child accomplish the following developmental milestones?

Rolled Over \_\_\_\_\_ Walked \_\_\_\_\_ First Solid Foods \_\_\_\_\_  
 Sat Alone \_\_\_\_\_ First Words \_\_\_\_\_  
 Crawled \_\_\_\_\_ Sentences \_\_\_\_\_

Please indicate behaviors which describe your child as an infant or young child. (Mark with a 'C' if this is a current behavior or 'P' if it was a previous behavior)

	Cries A Lot, Fussy, Irritable		Not Demanding		Alert
	Quiet or Passive		Likes Being Held		Drools Excessively
	Resists Being Held		Tense When Held		Very Active
	Good Sleep Patterns		Irregular Sleep Patterns		

Has your baby ever been described as "colicky"?  Yes  No

Other challenges?

When does your baby become the most frustrated?

Do you feel concerned about your baby's development (fine or gross motor)?

Does your baby resist tummy time?  Yes  No

When is your baby the most calm and happy?

**Thank you! We look forward to working with you and your child.**