Child Registration Form

Date: _____

Child's Name: _____ M / F **DOB:** _____

Primary Guardian's Name(s): _____

Address: _____

Phone: _____ □ permission to leave a detailed clinical voicemail
□ text message reminder

Email: _____ □ email appointment reminder

Preferred 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 clinical voicemail
□ text message reminder

Email: _____ □ email appointment reminder

Pediatrician: _____

Clinic Name: _____

Address: _____

_____

Phone: _____

Primary Insurance:

_____

Secondary Insurance (if applicable):

_____

School (if applicable): _____ **Teacher:** _____

Who referred you? _____

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 canceled 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 Jefferson County Public Schools are closed. These canceled 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 purposed 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/.

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

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
□ Exchange verbal information with
□ Pick-up/Drop-off Only

Name: _____
(Relationship to Child) _____
Address: _____
_____
Phone: _____

□ Release written medical records to
□ Exchange verbal information with
□ Pick-up/Drop-off Only

Name: _____
(Relationship to Child) _____
Address: _____
_____
Phone: _____

□ Release written medical records to
□ Exchange verbal information with
□ Pick-up/Drop-off Only

Name: _____
(Relationship to Child) _____
Address: _____
_____
Phone: _____

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

Child Registration Form

Child'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.

Primary Concerns

(Please check all that apply)

	Articulation		Attention		Auditory Processing		Balance		Big Body Movements
	Body Awareness		Comprehension of Language		Concentration		Coordination		Early Literacy Development
	Eating		Expressive Language		Eye Hand Coordination		Fears		Feeding/Swallowing
	Fine Motor Development		Frustration		Getting Along with Adults/Peers		Gross Motor Development		Handwriting
	Fluency/Stuttering		General Learning		Global Delays		Grammatical Development		Organization
	Math		Moodiness		Motivation		Neatness		Self-Care
	Play		Pencil Grasp		Reading		Safety		Voice Quality
	Self-Confidence		Sensory Processing		Spelling		Sports		Sleeping
	Social Skills		Waking Up						

What is the approximate date and/or age you first noticed your child's difficulties? _____
Please describe your child's challenges:

Please check if your child has had any previous evaluations or testing. If possible, include dates and copies of relevant documents.

□ Occupational Therapy
□ Physical Therapy
□ Speech Therapy
□ Neurological
□ Counseling
□ ABA
□ Behavior
□ Educational
□ Other _____

What was the diagnosis given?

Has your child had any therapy prior to coming to our clinic? □ Yes □ No

If so, what type of therapy, when, where, (school or private) and for how long? Are these treatments ongoing?

Pregnancy and Birth History

If your child was 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
Is 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 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) _____

Was your child breast fed or bottle fed (please circle)?
Until what age? _____

Did you experience any challenges with the transition between breast and bottle? □ Yes □ No
If yes, please explain.

Were there any problems with sucking or feeding during your child's infancy? □ Yes □ No
If yes, please explain.

Were there any challenges with the transition to solid foods? □ Yes □ No
If yes, please explain.

Medical/Developmental History
Has your child had any of the following? (Place a check by all that apply)

	High Fever		Mumps		Mono		Pneumonia		Chronic Stuffiness
	Meningitis		Scarlet Fever		Respiratory Problems		Influenza B		Weight Loss/Gain
	Chicken Pox		Seizures		Heart Trouble		Excessive Vomiting		Tonsillectomy
	Whooping Cough		Diabetes		Strep Throat		Ear Infections/Tubes		Chronic Constipation
	Chronic Diarrhea		Acid Reflux		Allergies		Concussion/Head Injury		Thumb/Finger Sucking
	Vision Problems		Sleep Disturbances		Adenoidectomy		Other:		

Please list specific allergies, if any:

Has your child had any hospitalizations or procedures?

Any physical/medical precautions or activity restrictions?

Is your child currently on any medications or supplements? □ Yes □ No
Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Please describe any history of vision or hearing problems:

Please list dates of most recent hearing and/or vision testing and results:
Hearing: _____
Vision: _____

Does your child have a history of frequent ear infections? □ Yes □ No

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

Rolled Over_____ Walked_____ First Solid Foods_____
Sat Alone_____ First Words_____ Dressed Self_____
Crawled_____ Sentences_____ Toilet Trained_____

Self-Care
Indicate 'I' for Independent, 'A' for Assistance needed or 'R' for Refuses.

	Toileting		Undressing		Self-Feeding Utensils
	Toileting-Bowel and Bladder Control		Dressing		Uses A Straw
	Brushing Teeth		Buttons		Uses Open Cup
	Washing and Drying Hands		Snaps		Sippy Cup
	Hair Washing		Zipping		Bedtime Rituals/Routines
	Socks		Velcro Shoes		Tie Shoes
	Morning Rituals/Routines				

Please elaborate if any of these routines are challenging for your child.

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		

Does your child tend to have difficulty learning new motor skills or games? □ Yes □ No

Is your child resistant to participation in motor skills or games? □ Yes □ No

Does your child appear to be right or left hand dominant (please circle)?

Are there any members of your family left hand dominant? □ Yes □ No

Behavior/Social Development

Behavioral Characteristics of your Child
(Place a check by all that apply)

	Cooperative		Attentive		Willing to Try New Activities
	Prefers to Play Alone		Separation Difficulties		Easily Frustrated/Impulsive
	Easy Going/Flexible		Immature for Age		Restless
	Poor Eye Contact		Easily Distracted/Short Attention		Aggressive
	Withdrawn		Stubborn		Social/Outgoing
	Mature for Age		Other:		

When does your child become the most frustrated?

When is your child the most calm and happy?

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