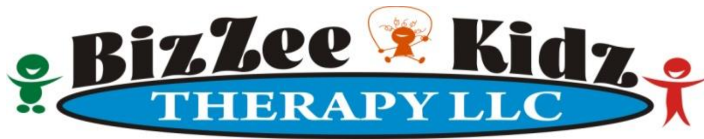

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
Patient's Legal First Middle and Last Name:					
Name he/she goes by:	(Former Name)	Social Security Number:	Birth Date:	Age:	Gender ___ Male ___ Female
Mothers First Name:		Mothers Last Name:		Cell Number:	
Fathers First Name:		Fathers Last Name:		Cell Number:	
Street address &/or PO Box:				Home phone number:	
City:		State:		ZIP Code:	
Referred to clinic by:					
Primary Physician:		Referring Physician			

INSURANCE INFORMATION			
After filling out as much information as you can please give your insurance card(s) to the receptionist to copy			
Insurance Subscriber's Name	His or Her Birth date: / /	Address (if different from above):	Home phone number:
Employer:		Employer Phone Number:	
Is the patient covered by insurance? ❑ Yes ❑ No	Primary Insurance: ❑ Medicaid ❑ Anthem/BCBS ❑ HealthLink ❑ Coventry ❑ United HealthCare ❑ TriWest ❑Other: ___________________________		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other - __________________________________			
Name of secondary insurance (if applicable):	Subscriber's name:	His or Her Birth Date:	Employer:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other - Explain			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone number:	Work or Cell phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Clinic. I understand that I am financially responsible for any balance. I also authorize BizZee Kidz Therapy, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

IMPORTANT INFORMATION

It is important that you be familiar with your insurance coverage for a specific therapy. In order to provide uninterrupted therapy treatment, it is necessary to be aware of what insurance requirements apply to your plan.

As a courtesy to you, our office can contact your insurance company to see what therapy benefits apply to your plan. **We are not responsible for the information we receive. Benefits are often misquoted over the phone. Final determination of benefits is established when a claim is submitted and either paid or denied. We strongly encourage you to call your insurance company and get information about your plan benefits for therapy. Please be aware of any copays or deductibles that may be due from you.** The contract with the insurance company is between you and that company, our office is not involved.

- **Please notify our office 24 hours in advance if you must cancel.** Patients on our waiting list can be seen when we have these openings.
- **"No-shows" and late cancellations (same day as therapy) adversely affect therapy and are costly to this office.**
- **A $25.00 charge will be applied for each 'no show' occurrence.**
- **3 "no shows" may result in loss of your therapy time slot.**
- We will bill your primary insurance.
- Co-pays are due at each visit.
- When we receive payment from your insurance, we will bill you for any outstanding balance. Payment is due upon receipt of your bill.
- Any unpaid patient balances over 60 days will be charged a 10% late fee.
- Patient balances unpaid after 90 days will be sent to collection.

If you change insurance plans or companies, please let us know as soon as possible to expedite correct billing. **The final responsibility for your insurance coverage and your therapy bill lies with you.**

Assignment and Release: I understand that I am financially responsible for payment to BizZee Kidz Therapy LLC for charges not covered by my insurance company (except for contractual discounts). I authorize BizZee Kidz Therapy LLC to release any information to my insurance company that is required for processing of this claim. I hereby authorize the therapy as prescribed by my physician. SPECIAL PROVISIONS FOR THIS ACCOUNT:

______________________________ ___________

Signature of Parent or Guardian Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: **BizZee Kidz Therapy, LLC**

Address: **4358 Highway PP**

City: **Poplar Bluff** State: **MO** Zip Code: **63901**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name _____________________________ Date of Birth ______________________

I understand that as a parent/caregiver of _____________________________ I am agreeing to have my child receive a range of services at BizZee Kidz Therapy, LLC. The type and extent of services that my child will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for my child. Typically, treatment is provided over the course of several weeks, but can vary depending on the needs of the child.

I understand that all information shared with the therapists at BizZee Kidz Therapy, LLC is confidential and no information will be released without my consent. During the course of treatment at the clinic, it may be necessary for the therapist to communicate with other therapy providers. While written authorization will not be requested, prior to any discussion with other therapists working for BizZee Kidz Therapy, LLC, I understand that the therapist will discuss these communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to the child or to another person, the therapist is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child is being sexually or physically abused or is at risk of such abuse, the therapist is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the therapist and the agency are bound by law to comply with such requests.

I understand that a range of therapy professionals, some of whom are students in training, provide services. All professionals-in-training are supervised by licensed staff. I understand that at times there may be future therapists observing the therapy sessions.

If I have any questions regarding this consent form or about the services offered at BizZee Kidz Therapy, LLC, I may discuss them with my therapist. I have read and understand the above. I consent to have my child participate in the evaluation and treatment offered to me by BizZee Kidz Therapy, LLC. I understand that I may stop treatment at any time.

_____________________________________ ___________________________

Signature Date

Case History Form

Date Completed: ___/___/_____ Child's name: ________________________________

Person completing this form: ____

Relationship to the child: ____

Who recommended you come to us: ____

What concerns do you have regarding your child: ____
____
____

1. Background Information

Date of Birth: ___/___/______ Age:________ ☐ Male ☐ Female

Address: ____

Mother's Name: _________________________________ Phone: __________________

Father's Name: _________________________________ Phone: __________________

Describe your child's home environment. Please include sibling's names & ages, and if living with parent's, caregivers, joint custody, etc. ____
____
____

Does anyone in your family have speech, developmental, neurological, or hearing problems? If yes please explain. _
____
____
____

Describe your concerns regarding your child's development: ____
____
____

Has there been a traumatic life event your child has been through? If yes, please explain: ____________________
____
____

Has your child been tested/evaluated for therapy services before? If yes, please include what type of therapy, when the testing occurred, and if there was any treatment's following the test/eval: ____________________________
____
____
____

List other specialists (neurologists, psychologist, etc) your child has seen and the conclusions: _______________
____
____
____

Has your child been given a diagnosis? If yes, please include it and the date the diagnosis was given: ____________
____
____

Has your child's vision been tested? Yes / No When? __________

Has your child's hearing been tested? Yes / No When? __________

Were there any findings? If yes, please explain: ______________________________

Does your child wear or utilize any assistive device(s)? __________________________

____ Hearing Aids ____ Augmentative Communication Device

____ Splints - Hands/Arms/Knees/Ankles ____Protective Head Gear

____Orthotic Inserts ____ Wheelchair ____ Walker / Crutch

II. Prenatal and Birth History

Length of pregnancy in weeks: __________ Was the baby considered full term? _________

Birth Weight: __________ 1 minute APGAR:_____ 5 minute APGAR: ____

Were there any complications during the pregnancy or birth? If yes, explain: ____________________
____
____

Type of delivery? ____________________ Were forceps used?______________

How long was the infants stay in the hospital following birth? ____________________

Were there any complications/concerns immediately following birth or during first few weeks of life? (Jaundice, swallowing, seizures, hospitalizations, etc)If so, please explain:______________________________
____
____
____

III. Developmental History

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

__________ Held head up __________Reached for an object

__________Followed objects with eyes __________Rolled from back to stomach

__________Sat up unsupported __________Crawled

__________Stood alone __________Walked alone

__________Fed self with spoon __________Dressed Self

__________Toilet Trained __________ Used a fork

At what age did the following speech/language milestones occur?

______________ Babbled or cooed ______________ Said first word

______________ Begin to use 2 word phrases ______________ Begin to use sentences

______________ Follow simple directions ______________ Pointed to objects

How does your child express him/her self? Please circle one.

Sentences Phrases 1 or 2 words Sounds and/or Gestures Other

How many words are in your child's vocabulary? ____________________

Does your child have any feeding/swallowing issues? If yes, explain: ____

____

____

What types of food does your child prefer? ____

What types of food does your child refuse? ____

List any supplements or medications your child is currently taking: ____

____

____

Does your child have any food allergies or follow a special diet? ____

____

____

IV. Medical History

Please list any conditions or surgeries that your child has experienced including age, and if it is current or resolved (Allergies, Chicken Pox, Epilepsy, Headaches, etc): ____

____

____

____

____

____

Has your child had or been involved in any major accidents, surgeries, or hospitalizations? If yes, please explain: ______

____

____

____

____

V. Educational History

Does your child attend: ☐ Day care ☐ Preschool ☐ School ☐ Other

Name of School: ____________________________________

Number of days per week in school? ______________

Does your child have a current IEP/IFSP? Yes / No

Is your child currently having difficulty at school or daycare? If yes, please explain: ____________________________
____
____

Please add any information that you think might be helpful in our evaluation of your child:

____
____
____
____
____
____
____