Welcome to Kids That Can!
Helping all kids play, learn, and grow to their ultimate potential.

We are looking forward to partnering with your family to help meet your child's therapy needs. To help us best serve your family, please read all instructions carefully and fill out forms completely. We recognize and appreciate the amount of effort and time you put into this task.

We will need **ALL** of the following items **PRIOR** to performing your child's evaluation:

1. Completed Child History Form
2. Signed Acknowledgement of Receipt of Privacy Policy and Procedures Form
3. Signed Authorizations and Consents Form
4. A prescription from your primary care physician, preferably with diagnosis code
5. Completed Feeding History (if applicable)
6. Signed copy of your child's current IFSP or IEP (if applicable)

You can provide these forms to us by any of the following options:

1. Mailing to 1130 Senoia Road, Suite A1, Tyrone, GA 30290 at least 1 week prior to appointment.
2. Faxing to 678-550-7931.
3. Delivering to our office during normal business hours (Monday –Thursday, 8:30am – 5:00pm).
4. Scanning and returning via email to frontdesk@kidsthatcan.com
5. Bringing to the clinic on the day of your appointment and arriving 15 minutes prior to appointment time.

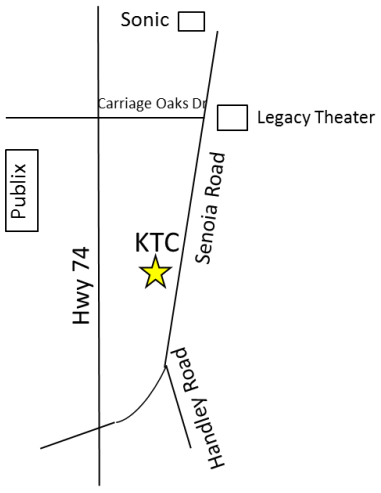
On the day of your child's evaluation, please also bring the following:

1. Your child's insurance card(s).
2. Your driver's license.
3. Any other prior therapy notes, evaluations and/or medical information that will assist us in treating your child.

PLEASE DRESS YOUR CHILD IN PLAY CLOTHES, TENNIS SHOES, AND SOCKS FOR THEIR SESSION.

We are located at:

Kids That Can!
1130 Senoia Road, Suite A1
Tyrone, GA 30290
FAX: 678.550.7931
Email: frontdesk@kidsthatcan.com



Please contact us at 678-632-6765 with any questions. We look forward to seeing you soon!

Child History Form

Child's Name: _____ Date Completing Form:_____

Child's Date of Birth: _____ Age: _____ Gender (Circle): Male Female

Home Address: _____

Home Phone Number: _____ Email Address: _____

Person Filling Out This Form: _____ Relationship to Patient: _____

Is your child adopted? Yes No

Please List All People Living in the Home:

First Name	Relationship to Child	Age	Any Developmental or Medical Problems

Please explain the concerns you have regarding your child
(**Be detailed and specific.** Please attach another page or use the back of this sheet if needed):

_____

_____

_____

_____

What are your goals and expectations for therapy?

_____

_____

_____

Does your child currently use any equipment, adaptive or assistive devices at home or at school? YES NO
If yes, please list: _____

_____

Child's Name: _____

Is your child currently receiving, or has your child in the past received any other therapy or undergone any other developmental testing? If so, please tell the type of therapy or testing, when it occurred, and who conducted it. Please attach another page or use the back of this sheet if needed and bring copies of any recent reports to the initial evaluation.

_____

_____

_____

_____

_____

Referring Physician: _____ Primary Care Physician:_____

Referring Physician Phone: _____ Referring Physician FAX: _____

Referring Physician Address: _____

Besides your child's pediatrician, please list health care providers (including other therapists) following your child and circle Yes or No regarding if we have your permission to contact this provider if it allows us to provide collaborative care and benefit your child. (Use the back or attach another sheet if needed)

Name of Provider	Phone Number	Reason for Following Child	Permission to Contact?
			YES NO
			YES NO
			YES NO
			YES NO
			YES NO

Please list any current medications, vitamins, or supplements your child takes
(Use the back or attach another sheet if needed):

Medication/Vitamin/Supplement	Reason for Taking

Child's Name: _____

Pregnancy/Birth History:

Was child full-term? (circle)

YES NO If no, what was gestational age at birth? _____

What was child's birth weight? _____

Was child born via C-section? YES NO

Was child a multiple birth? YES NO

Please list any problems during the pregnancy or at birth for the mother OR child:

_____

_____

_____

Did child require care in NICU following birth? (circle) YES NO If yes, for how long? _____

Did child require oxygen following birth? (circle) YES NO

If yes, for how long?_____

If yes, what type? (Circle) Ventilator CPAP Nasal Canula Unsure Other

Medical and Developmental History:

Does your child have a history of or currently have difficulty with any of the following? If yes, please explain and **give specifics** in the space provided. If you need more room, please attach another sheet or use the back of this page.

Sleeping NO YES _____

Eating NO YES _____

Infections NO YES _____

Hospitalizations NO YES _____

Surgery NO YES _____

Seizures NO YES _____

Vision NO YES _____

Hearing NO YES _____

Other NO YES _____

Has your child had a formal hearing assessment? YES NO If yes, by who? _____

Has your child had a formal vision assessment? YES NO If yes, by who? _____

If you answered yes to either of these questions, make sure findings are fully described above.

Child's Name: _____

School/Social/Extracurricular History:

Is your child in school or daycare? (Circle):

In-home Daycare Center-based Daycare Preschool Home School Elementary/Middle/High School

Name of School: _____Grade in School: _____ Days/Week in School:_____

May we contact school staff to collaborate if it could benefit your child? YES NO

Does your child have any of the following difficulties at school (please circle all that apply):

Writing Reading Spelling Math Attention Peer Relationships Behavior

Other: _____

Is your child left or right handed (Circle one)? LEFT RIGHT UNSURE

Is your child currently on an IEP or IFSP (circle): YES NO

If yes, what services do they receive (circle): OT PT Speech Other: _____

Name of OT/PT/ST(s) at school: _____

If your child has an IEP or IFSP, we must have a copy of the current IEP or IFSP at the time of the evaluation.

List any other activities your child participates in outside of school:

_____

Name of Person Completing This Form (Print): _____

Signature of Person Completing This Form: _____

Acknowledgement of Receipt of Privacy Policy and Procedures

Acknowledgement of Receipt of Privacy Policy

I have been given a copy of the Kids That Can! Notice of Privacy Practices and will review it and keep it on file.

Child's Name (print):_____Parent/Guardian Name (print):_____

Parent/Guardian Signature:_____ Date: _____

Acknowledgment of Kids That Can! Procedures

Kids That Can! policies and procedures regarding treatment of my child:

1) Payment for Services

It is the patient/parent(s)/guardian responsibility to inform Kids That Can! of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc. as soon as possible. Failure to do this could result in total patient responsibility for charges incurred. The undersigned agrees that in consideration of the therapy services to be rendered to the patient, he/she hereby obligates himself/herself to promptly pay any co-pay, coinsurance, deductible or non-covered service amount due on the date in which services are rendered. Any amount not paid within 3 months of the date of service will be subject to an interest rate of 1% per month and will be subject to collections. Both private insurers and the Federal Government prohibit waiving and/or reducing the co-payments and deductibles that are due by your specific policy. We are obligated to be in compliance with all these standards. Insurance policies are contracts made between the patient and the Insurance Company. We will verify your insurance benefits; however this is no way a guarantee of payment for therapy services. When insurance does not provide payment of therapy costs, payment of the bill is your responsibility. In the event that insurance does not cover your child's services, you will be billed a cash discounted rate of $100 for 1 hour treatment sessions and $200 for evaluations. This cash-discounted rate will be due at the time of service. Consultation to parents, teachers, IFSP/IEP teams, behavior specialists, etc cannot be billed to insurance payors, so these incur a self pay charge of $25 per 15 minutes of consult.

2) Cancellations

Your child's progress is dependent upon consistent availability for scheduled therapy sessions. We understand that unavoidable circumstances will come up, but ask for as much notice as possible when you will not be available for your session. Please contact our front desk directly when the need to cancel arises. Failure to attend a scheduled appointment without notifying the clinic will result in a $25 "no-show" fee, which is not payable by insurance companies and is your responsibility. T**hree "no-shows" and/or frequent cancellations** will result in discharge from Kids That Can! so we can accommodate other patients.

I have read and understand the above procedures regarding therapy with Kids That Can!

Child's Name (print): _____ Parent/Guardian Name (print):_____

Parent/Guardian Signature: _____ Date: _____

Authorizations and Consents

Authorization to Obtain/Release Medical Records

I authorize Kids That Can! to obtain and release all of my child's medical records, case records, case histories, and/or personal and regular files, for the purpose of financial reimbursement, continuity of care and case management from and to all current and former providers of medical services. I understand and agree that a photocopy or facsimile of this executed authorization is as valid as the original. Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization, and my consent has been made voluntarily.

Child's Name (print): _____Parent/Guardian's Name (print):_____

Parent/Guardian Signature:_____ Date: _____

Consent to Treat

I consent to necessary examination procedures and/or treatment for my child by Kids That Can!. I realize that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills and performance components the therapist may need to address. I consent to use of gross motor play with my child and exempt therapist(s) and employee(s) and owner(s) of Kids That Can! from any injury resulting from this type of play.

Child's Name (print): _____Parent/Guardian's Name (print):_____

Parent/Guardian Signature:_____ Date: _____

Consent to Bill Insurance

I authorize Kids That Can! to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to Kids That Can!. I understand that the patient or patient's family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full.

Child's Name (print): _____Parent/Guardian's Name (print):_____

Parent/Guardian Signature:_____ Date: _____

Notice Of Privacy Practices

Effective January 2016

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to makes changes in our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice Available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment, and health care operations. For example:

Treatment: We may use and disclose your health information to a physician or other health care provider proving treatment to you.

Payment: We may use and disclose your health information to obtain payment services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence of qualification of health care professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, and credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those describes in this Notice.

To your family and friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family, member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses and disclosers. In the event of your incapability or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use of disclose your health information what we are required to do so by law.

Notice Of Privacy Practices

Effective January 2016

Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may not disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail message messages, postcards, or letters).

PATIENT RIGHTS

Access: you have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other cost incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, health care operations and certain other activities, for the last 6 years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your requests must specify the alternative means or location, and provide satisfactory explanation will be handled under the alternative means location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complains to us and to Secretary of the Department of Health and Human Services if you believe that your privacy right have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

Right to Obtain a Paper Copy of this Privacy Summary Notice as well as the Full Privacy Notice.

Questions and Complaints

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and / or with the U.S. Department of Health and Human Services.

Notice Of Privacy Practices

Effective January 2016

For more information about HIPAA or to file a complaint:
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

This policy is provided by:
Kids That Can, LLC
105 Glendalough Court, Suite H
Tyrone, GA 30290
678-632-6765