

Kidz First Therapy
3680 NE Akin Dr., Suite 134
Lees Summit, MO 64064
Phone: 816-446-9018
Fax: 816-554-1379

Child Intake Form / History

Today's Date _____

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Male Female

Diagnosis (if known): _____

Parent(s) / Guardians: _____

Address: _____

City, State, Zip: _____

Phone #1: _____ Cell Home Work Other

Phone #2: _____ Cell Home Work Other

Email #1: _____ Email #2: _____

Emergency Contact Name: _____

Emergency Contact Relationship to Child: _____

Emergency Contact (Information): _____

Client's Physician: _____

Physician Phone Number: _____

Physician Address: _____

Physician NPI: _____

How did you hear about Kidz First Therapy?

Kidz First Therapy
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Fax: 816-554-1379
www.kidz1therapy.com

Consent for Services

I authorize Kidz First Therapy to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by [Private practitioners name or private practice name] in writing. In addition, [Private practitioners name or private practice name] may terminate services by notifying me in writing.

I do not give my consent or am withdrawing my consent regarding Kidz First Therapy rendering evaluation and therapy services to the client named below.

Print Name of Client

Date

Client Date of Birth

Signature of Client or Legal Representative

Relationship to Client

Consent for Services

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Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and [Private Practice Name] for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of [Private Practice / Private Practitioner Name] you are required to carefully review and sign our payment policy.

Fee Schedule

(Effective 01/01/2017)

Service #1	Evaluation	\$150 per hour
Service #2	60 min. tx	\$80 per hour
Service #3	45 min tx	\$65 per hour
Service #4	Consultation Fee	\$60 per hour
Service #5	No Show	\$30 per session

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due:

- At the time of service
- Within ___ days

We accept the following payment methods at this time Cash, Check, Credit Card and HSA

Checks should be made payable to Kidz First Therapy

We will provide you with an invoice outlining the services rendered and the amount charged.

Name of Client: _____ Date of Birth: _____

I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not

covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that [Private Practice Name / Private Practitioner] will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

I understand that all returned checks will be subject to a \$____ returned check fee. Charges incurred and not paid after ____ days may be turned over to a collection agency at the client’s expense. Overdue accounts may also be reported to a Credit Bureau.

I understand that I am responsible for all legal and collection fees, which [Private Practice Name / Private Practitioner] may incur if payment is not made in accordance with the terms and conditions herein.

I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within ____ weeks/days after the overpayment is discovered on the client’s bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client’s who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

I, understand that all cancellations require ____ hours notice and that there will be a ____ charge for any cancellations made less than ____ hours. This charge is my sole responsibility and will not be covered by a third-party source.

I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

Print Name of Client

Date of Birth

Signature of Guardian or Responsible Party

Relationship to Client

Private Practitioner / Witness

Date

Payment Policy & Fee Schedule (Effective 01/01/2019)

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Authorization for Credit Card Use

By signing this form you give [Private Practice Name / Private Practitioner] permission to debit your account for the amount indicated on or after the indicated date. This is permission for current and future services as outlined in this agreement, and does not provide authorization for unrelated debits or credits to your account.

Name on Card: _____

Billing Address: _____

Credit Card Type:

- Visa Discover
 Mastercard American Express
 FSA Other _____

Credit Card Number: _____

Expiration Date: _____ Card Identification Number: _____ (3 digits on back of card)

I, _____ (client or parent/guardian name) authorize [Private Practice / Private Practitioner Name] to charge fees rendered for therapy services to the credit card provided herein.

I understand that the provided credit card will be charged for services rendered (after each session / at the end of the month) and that I will receive a printed invoice as a receipt of payment.

Cardholder, please sign and date:

Print Name: _____ Signature: _____

Date: _____

Client Name: _____ Date of Birth: _____

Credit Card Authorization

I authorize [Private Practice Name/Private Practitioner] to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for therapy services, for the amount invoiced by the practice, and is valid for ongoing monthly and weekly services. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While [Private Practice / Private Practitioner Name] understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or “no shows”. Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted _____ hours prior to your scheduled appointment.

A fee of \$____ may be assessed if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.

- If cancellations are made less than the required ____ hours.
- If the client fails to show up for a scheduled appointment.

If you reschedule / are late for ____ scheduled appointments within [time period – 30 days / calendar year / a plan of care], the office will reserve the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

If you fail to appear for an appointment (no show) without providing the appropriate advance notification for _____ or more appointments within [time period – 30 days / calendar year / a plan of care], the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

Print Name of Client

Date

Signature of Client or Legal Representative Relationship to Client

Attendance / Cancellation Policy

HIPAA POLICY NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

[Private practitioners name or private practice name] is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information maybe used and shared.

I acknowledge that I have received a copy of [Private Practice / Private Practitioner Name's] HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

I understand [Private Practice / Private Practitioner Name] cannot disclose my health information other than as specified in the notice.

I understand that [Private Practice / Private Practitioner Name] reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

Print Name of Client

Date

Signature of Client or Legal Representative

Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.
HIPAA Privacy Notice Acknowledgement

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

Staff Member Signature

Date

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Acknowledgement & Assumption of Risk

I, _____ (client or parent/guardian name) understand that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to have _____ (client name) receive therapy services from Kidz First Therapy and/or any employee or independent contractor employed by Kidz First Therapy.

I acknowledge that there is some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.

Some of unlikely but potential injuries include:

I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding [Private Practice / Private Practitioner Name] and/or any employee or independent contractor employed by [Private Practice / Private Practitioner Name] accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

Print Name of Client

Date

Signature of Client or Legal Representative Relationship to Client

Acknowledgement & Assumption of Risk

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Communication Preference Form

Client Name: _____ Date of Birth: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to [Private Practitioner's Name or Private Practice Name] to do the following:

Written Documentation and Verbal Information

I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.

I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

I grant permission to provide me with written communication via USPS in an unmarked envelope.

I elect to receive clinical information in person or via telephone through the number provided.

I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information

Individual's Name Relationship to Client Email and/or Number

- 1.
- 2.

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

Print Name of Client

Date

Signature of Client or Legal Representative Relationship to Client

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General Acknowledgement of Forms

I hereby acknowledge and agree that I had read all of the forms and documents provided to me in connection with evaluation and treatment provided by [Private practitioners name or private practice name] and/or their employees.

I understand the meaning and intent of the provided forms and agree to all content included.

I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by [Private practitioners name or private practice name].

Print Name of Client

Date

Signature of Participant or Legal Representative

Relationship to Client

General Acknowledgement of Forms

Attendance and Record of Payment

Client Name: _____

Date of Birth: _____

Date of Service	<u>A</u>ttended <u>C</u>ancel / <u>N</u>o <u>S</u>how	Payment Amount	Payment Type	Signature of Responsible Party

