KENAI KIDS THERAPY, INC

SPEECH THERAPY | PHYSICAL THERAPY | OCCUPATIONAL THERAPY

35105 Kenai Spur Highway Ste. A ● Soldotna, Alaska 99669 ● Phone: 907-260-7444 ● Fax: 866-829-0999

# New Patient Intake Form

| CHILD INFORMATION | | | | PARENT/GUARDIAN INFORMATION | | | |
|---|---|---|---|---|---|---|---|
| **Name** | | | | **Mother** | | | |
| Date of birth | | Age | | DOB | | Home Ph | |
| Gender | | Doctor | | Cell Ph | | Work Ph | |
| Person Referring | | | | *Mailing Address* | | | |
| Medical Diagnosis | | | | City, State, Zip | | | |
| Current immunizations? | Yes ☐ No ☐ | | | *Physical Address* | | | |
| If "NO" give reason | | | | City, State, Zip | | | |
| Child resides with? | Parents ☐ Foster☐ | | | Occupation | | | |
| Who has custody of child? | Parents ☐ OCS ☐ | | | Employer | | | |
| *OCS Caseworker.* | Name | | | **Father** | | | |
| | Cell | | | DOB | | Home Ph | |
| *Person other than parent bringing child to therapy.* | Name | | | Cell Ph | | Work Ph | |
| | Cell | | | *Mailing Address* | | | |
| PRIMARY INSURANCE INFORMATION | | | | City, State, Zip | | | |
| Primary Insurance | | | | *Physical Address* | | | |
| Policy Number | | | | City, State, Zip | | | |
| Group Number | | | | Occupation | | | |
| Expiration | | | | Employer | | | |
| Claims Address | | | | ***May we send out an appointment reminder via text or unencrypted email?*** ☐ Yes ☐ No<br>☐ Text Cell ph #: ______________________________<br>☐ Email Email Address:___________________________<br>☐ Both | | | |
| Phone Number | | | | | | | |
| Insured's Name | | | | | | | |
| Insured's DOB | | | | ***May we email (not encrypted) requested medical records or therapist communication to you?*** | | | |
| SECONDARY INSURANCE INFORMATION | | | | | | | |
| Secondary Insurance | | | | ☐ Yes ☐ No Email Address:_______________________ | | | |
| Policy Number | | | | ☐ I authorize Kenai Kids Therapy to submit bills directly to the insurance carrier(s) for payment. | | | |
| Group Number | | | | | | | |
| Expiration | | | | ☐ I authorize insurance carrier(s) to make payments to Kenai Kids Therapy. | | | |
| Claims Address | | | | | | | |
| Phone Number | | | | ☐ I understand that Kenai Kids Therapy may be billing the Infant Learning Program (ILP) for my child while enrolled in ILP. Once my child is discharged from ILP, I hereby give Kenai Kids Therapy permission to bill my insurance carrier(s) directly for payment. | | | |
| Insured's Name | | | | | | | |
| Insured's DOB | | | | | | | |

| **Parent or Legal Guardian Signature** | | **Date** | |
|---|---|---|---|

*Updated 08/01/2020*

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**Name of Child**

List all the names of providers and programs that have worked with or are currently providing services to your child.
** Physicians, teachers, therapists, day care, counselor, etc.*

| Name of Provider and Program | Phone Number | Dates |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## PERMISSIONS

☐ I give permission for students/shadows to observe my child for the purpose of education.

☐ I give permission to photograph/videotape my child for the purposes of treatment, education, and/or documentation.

☐ I give permission to photograph/videotape my child to be used for advertising, brochure, and/or web space.

## Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

☐ I acknowledge that I have viewed and been offered a copy of the Notice of Privacy Practices.

## EMERGENCY CONTACT NAME (other than self)

| Name | | Relationship | | Phone Number | |
|---|---|---|---|---|---|
| Name | | Relationship | | Phone Number | |

## EMERGENCY MEDICAL RELEASE

☐As legal guardian of this child, I give my permission for Kenai Kids Therapy, in the event medical attention is required for your child while on the premises of Kenai Kids Therapy to provide basic life support medical treatment and/or to contact emergency personnel in the event of a medical emergency.

## EVALUATION CONSENT

During the evaluation the therapist may assess your child's abilities in one or more of the following areas: communication, social, play, problem solving, sensory, motor, body structures. The evaluating therapist may use one or more of the following procedures: caregiver interview, medical record review, clinical observation, developmental tests, body structure exam. Minor risks may include irritability, fatigue, and/or tired muscles.

☐I give consent for my child to be evaluated today.

## TREATMENT CONSENT

Following evaluation the therapist will review the findings with you and recommend treatment interventions for your child. Therapeutic interventions in one or more of the following areas may include: education, home program, communication, language, social, play, daily living activities, sensory, motor, exercise, positioning, taping, orthotics, equipment fitting. Minor treatment risks may include irritability, fatigue, and/or tired muscles.

☐If treatment is recommended I give consent for my child to receive the agreed upon therapeutic interventions.

| **Parent or Legal Guardian Signature** | | **Date** | |
|---|---|---|---|