Kid-Pro Therapy Services, Inc
16546 N. Dale Mabry Hwy.
Tampa, FL 33618
Ph. (813) 964-8481
Fax (813) 964-8431

THE BOAS CENTER
Opening Doors for Communication & Learning

Welcome to Our Office: This Form Must Be Completed In Its Entirety!!! **Date: / /**

PATIENT INFORMATION

Patient Name :_____

☐ Male ☐ Female

Birthdate_____/____/_____ Age_____ S.S.#_____

Home Address_____

City_____ State _____ Zip_____

Home Phone #_____

Whom may we thank for referring you?_____

Pediatrician_____ Phone #_____

School _____

Teacher_____ Grade_____

Any grades repeated? ☐ YES ☐ NO If yes, grade_____

May we contact your child's teacher regarding any findings? Y N

Parents Signature_____

FAMILY INFORMATION

Mother/ Guardian_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birthdate_____/____/_____ Age_____ S.S.#_____

Cell Phone #_____Wk #_____

Email Address_____

Employer_____ Occupation_____

Is mother living with family? ☐ YES ☐ NO

If no, address_____

_____

Father/ Guardian_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birthdate_____/____/_____ Age_____ S.S.#_____

Cell Phone #_____Wk #_____

Email Address_____

Employer_____ Occupation_____

Is father living with family? ☐ YES ☐ NO

If no, address_____

_____

Is child adopted / foster care? ☐ YES ☐ NO

SIBLINGS Name Age

_____ _____

_____ _____

_____ _____

_____ _____

Any family member with speech/language or learning difficulties?

☐ YES ☐ NO If yes, explain_____

_____

INSURANCE INFORMATION

Front & Back Copy of Insurance Card is Required

Primary Insurance_____

Claims Address_____

City_____ State_____ Zip_____

Phone #_____

Insured Name_____

I.D. #_____ Group #_____

Secondary Insurance_____

Claims Address_____

City_____ State_____ Zip_____

Phone #_____

Insured Name

PERSON RESPONSIBLE FOR PAYMENT

Name_____

Home Address_____

City_____ State_____ Zip_____

Home Phone #_____

Relationship_____

PAYMENT AUTHORIZATION

I request that payment of authorized insurance company benefits be made on my behalf to Kid-Pro Therapy Services, Inc./The Boas Center for any services furnished to me or my child by that physician/supplier. I authorized any holder of medical information about me or my child to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment to the above provider be made and authorized release of medical information necessary to pay the claim.

Signature _____

Date _____

I AGREE TO PAY FOR ALL PROFESSIONAL SERVICES RENDERED. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, I AM RESPONSIBLE FOR ALL FEES, (WITHIN 60 DAYS) REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER. IF IN THE EVENT COLLECTION AGENCY OR ATTORNEY FEES ARE INCURRED IN ORDER TO COLLECT ON MY ACCOUNT. I WILL BE HELD RESPONSIBLE FOR SAID FEES.

Signature _____

Date _____

It is your responsibility to pay your co-payment for each visit and for visits not cancelled at least 6 hours before the scheduled appointments.

MEDICAL HISTORY

Length of pregnancy_____

During pregnancy did mother use; ☐ Alcohol

☐ Prescribed drugs If yes, what?_____

☐ Non prescribed drugs If yes, what?_____

During pregnancy and delivery - Check all that apply

☐ excessive bleeding	☐ prolonged bed rest	☐ surgery
☐ hospitalization	☐ prolonged labor	☐ toxemia
☐ induced labor	☐ oxygen deprivation	☐ seizures
☐ jaundice	☐ gestational diabetes	☐ preclampsia
☐ accident/fall	☐ breathing problems	

☐ incubator – how long?_____

☐ meconium staining or aspiration

☐ umbilical cord wrapped around neck

☐ required stay in neonatal intensive care (NICU)

If yes, Why? _____

Birth History

☐ vaginal ☐ cesarean delivery, Birth Weight_____

Other medical history

☐ febrile seizures	☐ bronchitis	☐ meningitis
☐ seizures	☐ cleft palate	☐ short frenum
☐ skull fracture	☐ Down Syndrome	☐ fragile X
☐ allergies	☐ asthma	☐ Cerebral Palsy
☐ Autism	☐ Attention Deficit Disorder	
☐ encephalitis		

Does the child have any muscloskeletal deformities (i.e. dislocated hips)?

☐ YES ☐ NO

☐ surgeries If yes, for what_____

☐ EEG – Physician_____

date_____ Results_____

☐ MRI – Physician_____

date_____ Results_____

☐ CAT SCAN - Physician_____

date_____ Results_____

☐ Psychological Evaluation - Psychologist_____

date_____ Results_____

☐ Developmental Screening - Agency_____

date_____ Results_____

More than 6 ear infections before 18 months? ☐ YES ☐ NO

Was medication prescribed? ☐ YES ☐ NO

Insertion of tubes? Age_____ ☐ YES ☐ NO

How many sets of tubes?_____

Date of most recent hearing / vision test:_____

Where?_____

Does the child lose balance easily? ☐ YES ☐ NO

DEVELOPMENTAL MILESTONES (Age when occurred)

_____ Babbled

_____ 2 word sentences (sit here)

_____ 3-4 word sentences (I want candy)

_____ Understood by all family members

_____ Understood by friends and public

_____ Head Control _____ Walking _____ Sitting Alone

_____ Creeping _____ Riding a tricycle

ORAL MOTOR -Check all that apply

☐ sucking difficulties as infant	☐ choking episodes
☐ normal gag reflux	☐ swallowing difficulty
☐ drooling (past 9 months)	☐ mouth breather
☐ limited food choices	☐ sucks thumb
☐ feeding problems/breast/bottle	

BEHAVIOR -Check all that apply

☐ easy going	☐ Responds well to others
☐ shy	☐ Fails to respond to name when called
☐ aggressive	☐ non-compliant when asked to do new things
☐ withdrawn	☐ Poor eye contact during conversation
☐ easily bored	☐ often interrupts others

☐ non-compliant when asked to do familiar tasks

☐ different from other children in family

☐ difficulty following movies or television

SPEECH AND LANGUAGE -Check all that apply

☐ responds to hi / bye

☐ does not use "I"

☐ understands common words (mom, dad, baby, cookie, no)

☐ vocalizes or gestures for needs

☐ appears interested in conversation

☐ plays with toys appropriately (trucks, dolls, cooking tools)

☐ had sounds and lost them

☐ primarily repeats sounds / words of others

☐ does not differentiate between yes / no

☐ does not ask simple questions

☐ confuses gender (uses he for she)

☐ difficulty with use of pronouns (him, her, he, she)

Therapeutic Adaptation:

Does the child use any Assistive/Adaptive Equipment, Orthotics, Prothetics, Communication Devices (i.e., walker, splint, AFO, DynaMyte, picture symbol book)? ☐ YES ☐ NO

Parents Comments:

_____

_____

_____

_____

_____

_____

_____

Kid-Pro Therapy Services, Inc. / The Boas Center

Thank you for choosing Kid-Pro Therapy Services, Inc / The Boas Center. We look forward to providing therapy for you or your family member. We appreciate your commitment to improving your/or your child's communication. The therapy time that has been given to you is very important and you will want to make every effort to attend your scheduled appointments. We think it is important for you to know our financial policy and appointment/cancellation policy before we begin therapy services.

Financial Policy

- If you have any questions regarding financial or billing issues please direct these to our office manager at (813) 964-8481.
- Payment for services are expected at the time services are rendered. The office will file your insurance claim but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefits.
- ***If you are planning to change insurance carriers, please notify us well in advance*** so we can obtain authorization from the new carrier. This will help prevent a lapse in therapy.
- Any conference on or off-site is your financial responsibility. As a courtesy, we will bill your insurance company.

Cancellation Policy and Missed Appointments

- ***Please do not bring your child to therapy if she/he is running a temperature or may have an infectious illness (chicken pox, pink eye, impetigo, green discharge from nose, etc.).***
- Therapy is usually scheduled for half-hour sessions and time cannot be lengthened to make up for late arrivals.
- A therapy session includes two important parts which are: a) direct treatment and b) consultation time. Direct treatment will be stopped at least 5 minutes before the end of a session to allow for consultation time to discuss with you the daily session, homework assignments, etc.
    - ***Appointments are scheduled at the same time each week.***
    - ***Please notify our office within 24 hours if you need to cancel your therapy session. If a cancellation is received after that time, you will be responsible for the full session fee (not just a co-payment). To cancel appointments, you may leave a voicemail message with your therapist or leave a voicemail message with the main office at extension 301. Insurance companies do not reimburse for no-show or late cancellation appointments.***
    - ***Two missed appointments without notification will result in the therapy being discontinued.***
    - ***More than one cancellation in a three-week period without rescheduling will result in discontinuation of therapy.***
    - ***We will notify you as soon as possible if your clinician must be absent from a session.***

We regret that we have had to develop this policy, but due to a waiting list and demand for after school appointments, this policy is a necessity.

Please try to schedule any other appointments, such as a doctor's appointment, at a time that is not during your scheduled therapy time. Your clinician will make every effort to reschedule the appointment, if possible.

If you need to change your scheduled time, talk to your clinician and every effort will be made to choose a time that works for you.

Please take a moment to fill out the form on the bottom of the page and return it to your clinician. We will keep it in our files as a record that you have been informed of our policy. If you have any questions about this policy, please talk to your clinician.

I have read the guidelines and appointment/cancellation policy and understand:

PATIENT NAME_____

PARENT/PATIENT SIGNATURE_____ DATE_____

16546 North Dale Mabry Hwy.
Tampa, FL 33618
(813) 964-8481 (813) 964-8431 fax

3825 Henderson Blvd. Suite 601
Tampa, FL 33629
www.kidprotherapy.com

RELEASE OF INFORMATION

I authorize Kid-Pro Therapy Services, Inc. / The Boas Center to release the records of

_____ to _____ .
(patient name)

Signature _____

Date _____

STUDENT OBSERVATION

Occasionally we have students from USF observing therapy sessions to prepare them for the field of speech and language pathology. Please sign below if you consent to have your sessions observed.

Signature _____

Date _____

REQUEST FOR INFORMATION

I authorize the release of information from your office _____to Kid-Pro Therapy Services, Inc. / The Boas Center regarding _____.

Signature _____

Date _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Kid-Pro Therapy Services, Inc / The Boas Center's Notice of Privacy Practices.

_____ _____
Please sign your name Date

_____
Please print your name

If you are a legal representative of the patient, please print the name(s) and describe your relationship.

_____ _____
Representative's Relationship to Patient Patient Name

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LATE CANCELLATION AND NO-SHOW POLICY

Kid Pro Therapy Services will begin charging for appointments that are cancelled less than 24 hours in advance as well as for appointments for which clients do not show (and have not previously cancelled). Insurance companies will only cover for services rendered, not for appointments that are not held. Therefore, the client is responsible for the full fee if an appointment is not cancelled within a timely manner as stated above.

You as the client need to maintain an 80% attendance record for the month. If this percentage is not maintained each and every month, you will receive a letter stating that you or your child has been dropped from the schedule.

We maintain this policy in order to provide the best services possible and to make efficient use of available office hours. We keep a waiting list of clients who would like to be seen if an appointment becomes available. Appointments that are cancelled with very short notice or for which clients do not show make it very difficult for us to offer that time to someone else.

To schedule or cancel an appointment, please call your therapist first, then call the office. If you have any questions regarding this policy, please feel free to inquire.

Thank you for your understanding.

Management

I understand and will fully comply with this policy.

_____ _____

Signature **Date**

EMERGENCY INFORMATION

Child:_____ DOB:_____
Address:_____
_____
___
Allergies/Precautions:_____
Current Medications:_____
Parents:_____ Home #_____
Cell#_____ Cell#_____
Primary Doctor_____ Phone #_____

In the event that parents can't be reached, please list two other individuals who can be contacted in an emergency.
Name:_____ Phone #_____
Relationship to child:_____
Name:_____ Phone #_____
Relationship to child:_____

I give my permission to Kid Pro Personnel to administer minor first aid to my child,_____.

_____
Parent/Legal Guardian Signature Date

In the event of a serious emergency and parent/legal guardian cannot be reached, I give my permission to hospital staff/emergency medical personnel to provide care for my child,_____.

_____
Parent/Legal Guardian Signature Date