



Client Information Form

Please read, complete and sign all pages. Please print clearly.

PERSONAL INFORMATION:

Today's Date: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ SEX:  M  F DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

PARENT(S)/LEGAL GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

STREET

CITY, STATE, ZIP

HOME #: \_\_\_\_\_ Mom's CELL #: \_\_\_\_\_ Dad's CELL #: \_\_\_\_\_ OTHER: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

\*Used by Coastal Therapy staff for scheduling/billing purposes only and will NOT be shared for any other reason.

SIBLING(S) NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SIBLING(S) NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ARE BOTH PARENTS IN THE HOME?  Yes  No

IS YOUR CHILD ADOPTED?  Yes  No

EMERGENCY CONTACT:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PEDIATRICIAN NAME: \_\_\_\_\_ OFFICE NAME: \_\_\_\_\_

PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

RELEASE OF INFORMATION TO PEDIATRICIAN: I authorize Coastal Therapy & Learning Center to release any therapy notes, evaluations or test results to my child's pediatrician listed above.

Parent Signature

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: \_\_\_\_\_ NAME OF SUBSCRIBER: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_ SUBSCRIBER SSN#: \_\_\_\_\_

\* PLEASE PROVIDE YOUR INSURANCE CARD AS WELL AS ANY SECONDARY INSURANCE INFORMATION.\*



**SPEECH AND LANGUAGE HISTORY:** \*Please answer the following if your child is receiving speech therapy.\*

Age when first word was spoken: \_\_\_\_\_ Child's first words included: \_\_\_\_\_

How does your child tell you what he/she wants? Check all that apply.

- Does not communicate needs.
- Points/Gestures/Sounds
- Leads adult by hand.
- Single Words    How many? \_\_\_\_\_    Examples: \_\_\_\_\_
- 2-3 Word Combination    Examples: \_\_\_\_\_
- Long Complex Sentences    Average Length: \_\_\_\_\_

How well is the child understood by the family?

- Well
- Not Very Well

Do others understand your child?

- Well
- Not Very Well

Does your child understand you?

- Always
- Sometimes
- Never

When did you first become concerned about your child? \_\_\_\_\_

Has your child been given a diagnosis, including any medical conditions? \_\_\_\_\_

Do you have any concerns about your child's hearing? \_\_\_\_\_

Has your child ever had his/her hearing tested?     Yes     No

If yes, where: \_\_\_\_\_ Date of Testing: \_\_\_\_\_

Results: \_\_\_\_\_

Has your child had any previous therapy? (i.e. occupational, physical, speech) If yes: what, when and where.

\_\_\_\_\_

Is another language spoken in the home other than English? \_\_\_\_\_

Is there any family history of speech and language disorders? \_\_\_\_\_

**OTHER**

What are your child's favorite activities, toys, characters from books, TV, movies, etc?

\_\_\_\_\_

How much time are you able to spend reinforcing target therapy goals with your child at home?

\_\_\_\_\_

Does your child get along with other children? \_\_\_\_\_

What do you consider to be your child's strengths? \_\_\_\_\_

What do you consider to be your child's weaknesses? \_\_\_\_\_

## DEVELOPMENTAL HISTORY

Please give the approximate age (years/months) when your child...

- |                              |       |   |       |
|------------------------------|-------|---|-------|
| - Toilet Trained             | _____ | - Independently pulled self up to standing position | _____ |
| - Sat alone                  | _____ | - Self Fed w/ a spoon                               | _____ |
| - Stood alone                | _____ | - Crawled   | _____ |
| - Babbled                    | _____ | - Walked alone                                      | _____ |
| - Independently held head up | _____ |   |       |

Please give the approximate age (years/months) your child started/stopped using the following:

- |                        | Started | Stopped | Never used before        |
|------------------------|---------|---------|--------------------------|
| - Pacifier             | _____   | _____   | <input type="checkbox"/> |
| - Thumb/finger sucking | _____   | _____   | <input type="checkbox"/> |
| - Bottle               | _____   | _____   | <input type="checkbox"/> |
| - Sippy Cup            | _____   | _____   | <input type="checkbox"/> |
| - Open Cup             | _____   | _____   | <input type="checkbox"/> |
| - Utensils             | _____   | _____   | <input type="checkbox"/> |

Can your child complete the following tasks?

- Take clothes off (what items): \_\_\_\_\_
- Put clothes on (what items): \_\_\_\_\_
- Manipulate fasteners (open/close buttons, snaps, zippers): \_\_\_\_\_

Child's development can be rated as:       normal    fast    slow      Coordination is:  good    clumsy

Do you have any concerns about your child's fine or gross motor skills? (i.e. walking, running, balance, eating, chewing, drooling)

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### Additional Questions

- |  |                          |     |                          |    |
|--|--------------------------|-----|--------------------------|----|
| Does your child express distress during grooming?                    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child avoid messy play?                                    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Is your child a picky eater, especially regarding food textures?     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child become distressed when feet leave the ground?        | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child fear falling or heights?                             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child enjoy strange noises/Seeks to make noise?            | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child seek movements that interfere with daily routines?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child have difficulty paying attention?                    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child have trouble holding/using scissors/pencils/Crayons? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child respond negatively to unexpected or loud noises?     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child hold hands over ears to protect them from sound?     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child like to be held?                                     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Does your child pull away from people?                               | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

### Additional Concerns

Please list any additional concerns regarding your child's developmental milestones: \_\_\_\_\_

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COASTAL THERAPY & LEARNING CENTER, INC.

HIPPA NOTICE OF PRIVACY PRACTICES

**This notice describes how medical information about your child may be used/disclosed and how to access this information.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment**

Your protected health information will be used, as needed, to obtain payment for you health care services.

**Health Care Operations**

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you byname in the waiting room when a physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures**

These will be made with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosures indicated in the authorization.

**You have the right to inspect and copy your protected health information.**

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You may have the right to request a restriction of your personal health information.**

This means you may ask us not to disclose any part of your protected health information for the purposes of treatment, payment or health care options. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosures of your protected health information, our protected health information will not be restricted. You then have the right to use another Health Care Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Child's Name: \_\_\_\_\_

**Financial Policy**

Thank you for choosing Coastal Therapy & Learning Center to help your child succeed. This is a statement of our financial policy which we require to be signed prior to your child's first visit.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PREAPPROVAL FROM YOUR INSURANCE COMPANY IS OBTAINED**

**Insurance: \_\_\_\_\_ Initial**

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible for payment of all charges incurred for services and procedures rendered at Coastal Therapy and Learning Center. I understand that Coastal Therapy will obtain a verbal approval from my insurance company to verify benefits, prior to the patient receiving therapy. Verbal approval is not a guarantee of payment. A written explanation of payment is the only guarantee of coverage. This will also provide deductible, co-payment, and patient responsibility information. Once the EOP is received by Coastal Therapy, the patient responsibility amount is due. Should the insurance carrier process/pay a claim in error, the balance due for services is ultimately the responsibility of the guarantor. If there is a deductible, full payment is required until the deductible is met.

**Pre-Authorizations: \_\_\_\_\_ Initial**

Should the patient's plan require a pre-authorization or referral, it is ultimately the guarantor's responsibility to verify that a valid pre-authorization or referral from the child's primary care physician is on file with their insurance carrier before services are rendered.

**Off-Site Therapy: \_\_\_\_\_ Initial**

A credit card is required to be on file for all services rendered outside of the office prior to the first visit.

**Returned Check Policy: \_\_\_\_\_ Initial**

A fee of \$25 will be charged for each returned check. Once a check is returned only credit/debit card and cash payments will be accepted.

**Cancellation Policy \_\_\_\_\_ Initial** At Coastal Therapy and Learning Center cancellation is required 24 hours in advance of the scheduled appointment time. A fee of \$50.00 will be applied for all cancellations made without 24 hours notice. After accumulation of 3 cancellation fees, the full rate of therapy will be charged for each following no-show/last minute cancellation. Your insurance will not cover this charge. If your child is sick we required cancellation no later than 8am the day of the scheduled appointment. This notice is necessary so that cancelled therapy times can be offered in a timely manner to other clients waiting to be seen. We thank you for your understanding in this matter as we strive to meet the needs of all of our clients.

**Collections Policy \_\_\_\_\_ Initial** All accounts that are 30 days over due and a prior payment arrangement has not been established with the front office, the balance will be forwarded to a collections agency and the patient is responsible for all collections fees.

**By signing the following, you agree to these terms, and that all of the information provided is accurate.**

\_\_\_\_\_  
Guarantors Signature                      Print Name    Date

**CREDIT CARD AUTHORIZATION**

Cardholder Name: \_\_\_\_\_ Security Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\*I authorize charges to this credit card for any services provided by Coastal Therapy not covered by insurance. This includes, but is not limited to, deductible charges and co-payments.

Credit Card (circle one):              MasterCard              Visa              American Express

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
Cardholder Signature    Date