

NEW PATIENT PACKET



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www.BabyStepsTherapy.com

Date of Birth: ____ / ____ / ____ Age: _____ Gender: _____ Medical Record Number: _____

Patient's last name: _____ First: _____ M.I. _____

Mother's last name: _____ First: _____ M.I. _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

E-mail Address: _____

Father's last name: _____ First: _____ M.I. _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

E-mail Address: _____

Who referred you to us? _____

CUSTODY AND LIVING ARRANGMENTS:

With whom does your child reside? Both Parents Mother Only Father Only Split Custody Other: _____

If split custody, please describe: _____

List siblings living with your child: (Names and ages) _____

Please list any other information about your child's living arrangements that you feel would be helpful:

I declare the above statements regarding custody and living arrangements to be true and accurate. I understand that if custody arrangements change to the point they will affect my child's therapy, I am obligated to notify Baby Steps Therapy immediately.

Signature: _____ **Date:** _____

Relationship to Child: _____

Name of patient's primary doctor _____

Office Address _____

Phone # _____ Fax # _____



PRIMARY INSURANCE INFORMATION:

Insurance Subscriber's Name: _____ DOB of Subscriber _____

Name of Insurance Company _____ Provider Phone number for Insurance: _____

Effective Date: _____ ID # _____

SECONDARY INSURANCE INFORMATION:

Insurance Subscriber's Name: _____ DOB of Subscriber _____

Name of Insurance Company _____ Provider Phone number for Insurance: _____

Effective Date: _____ ID # _____

Do you have Medi-Cal? Y N (Please note- Baby Steps Therapy is **not** a Medi-Cal provider)

MEDICAL HISTORY

Please list your main concerns regarding your child **in order of importance** to you:

- 1.
- 2.
- 3.
- 4.

What are your child's current medications? _____

Allergies: _____

Has your child ever had a bad or unusual reaction to any food or drug? If "Yes, explain: _____

Does your child see any other physicians / specialists that you would like us to know about? _____

Does your child have a medical diagnosis? If yes, please state. _____

Does anyone in your child's family have a related diagnosis? If so, whom and what diagnosis? _____

List any previous medical/surgical procedure and/or hospitalizations (include date and explain) _____

Has your child ever been exposed to a contagious illness or required contact isolation (CMV, MRSA, TB)? If so please explain.

Has your child ever been on a long-term program of medication? _____

Medication and regimen: _____

GENERAL HEALTH:

Has your child been diagnosed with or had any of the following: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Congenital Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Attention Disorder | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Other Behavioral/Psychological Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Learning Disorder |
| <input type="checkbox"/> Autism/Pervasive Developmental Disorder | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Orthopedic Injuries | <input type="checkbox"/> Enuresis/Encopresis |
| <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Nerve Injury | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> High Fevers | <input type="checkbox"/> Sensory Processing Disorder | <input type="checkbox"/> Obsessive-compulsive Disorder |
| <input type="checkbox"/> Speech/Language Delay | <input type="checkbox"/> Respiratory Difficulties | |
| <input type="checkbox"/> Auditory Processing Disorder | <input type="checkbox"/> Gastrointestinal Disorder | |

Comments: _____

SLEEP:

Describe any concerns about sleep habits (i.e. - restlessness, staying up late, difficult to arouse in the morning)
Indicate number of hours of sleep per night. Please indicate whether sleep is uninterrupted or interrupted:

EDUCATION:

School you child currently attends: _____ **Location:** _____

Grade: _____

School Schedule:

	Mon	Tuesday	Wed	Thurs	Fri	Sat/Sun
Start time:	_____	_____	_____	_____	_____	_____
End time:	_____	_____	_____	_____	_____	_____

Do you have any concerns about your child's school performance? _____

PREGNANCY AND BIRTH HISTORY:

What was your child's birth weight?

Were there any complications during the pregnancy/delivery?

Was your child born at full term?

Did you take any medications during pregnancy? Describe:

Were alcohol or drugs used during pregnancy?

Were there any of the following complications during or after the birth? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Assisted delivery | <input type="checkbox"/> Congenital Defects | <input type="checkbox"/> Hypotonia |
| <input type="checkbox"/> Respiratory difficulties | <input type="checkbox"/> Feeding Difficulties (sucking, swallowing) | <input type="checkbox"/> Need for oxygen |
| <input type="checkbox"/> Cesarean Section | | <input type="checkbox"/> Supplemental nutrition |
| <input type="checkbox"/> Transfusions | | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> NICU | <input type="checkbox"/> Tube feeding | <input type="checkbox"/> Breech |

SELF HELP SKILLS: Mark "I" for Independent, "N" for Needs Help

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Eating | <input type="checkbox"/> Shoes | <input type="checkbox"/> Drinking |
| <input type="checkbox"/> Brushing Hair | <input type="checkbox"/> Finger Foods | <input type="checkbox"/> Socks | <input type="checkbox"/> Open cup |
| <input type="checkbox"/> Brushing Teeth | <input type="checkbox"/> Utensils | <input type="checkbox"/> Shirt | <input type="checkbox"/> Straw |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Fork | <input type="checkbox"/> Tie shoes | <input type="checkbox"/> Sippy cup |
| <input type="checkbox"/> Pants | <input type="checkbox"/> Spoon | <input type="checkbox"/> Buttoning | <input type="checkbox"/> Toileting |
| <input type="checkbox"/> Zipping | <input type="checkbox"/> Snapping clothing | <input type="checkbox"/> Snapping fingers | |

PLEASE LIST THE TYPES OF THERAPIES YOUR CHILD HAS PREVIOUSLY HAD OR IS CURRENTLY RECEIVING:

- 1. Type:** _____ **From:** _____ **To:** _____

Location: _____

DAYS/TIMES IF CURRENTLY RECEIVING: _____
- 2. Type:** _____ **From:** _____ **To:** _____

Location: _____

DAYS/TIMES IF CURRENTLY RECEIVING: _____

DEVELOPMENTAL HISTORY (PLEASE SKIP IF YOUR CHILD IS OVER AGE 5)

At what age did your child:

If unsure of exact ages, please note whether each milestone was early (E), on-time (O) or delayed (D)

- | | |
|--|--|
| <input type="checkbox"/> Lift head when lying on stomach | <input type="checkbox"/> Pull to stand |
| <input type="checkbox"/> Roll over stomach to back | <input type="checkbox"/> Walk independently |
| <input type="checkbox"/> Roll over back to stomach | <input type="checkbox"/> Hold a pencil/make markings |
| <input type="checkbox"/> Sit up when placed | <input type="checkbox"/> Coo prolonged verbal sounds |
| <input type="checkbox"/> Sit up independently | <input type="checkbox"/> Babble repeated syllables |
| <input type="checkbox"/> Crawl on belly | <input type="checkbox"/> Speak first word |
| <input type="checkbox"/> Creep on hands or knees | <input type="checkbox"/> Put two words together |
| <input type="checkbox"/> Complete toilet training | |

Additional Comments: _____

SENSORY

Does your child exhibit any of the following? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Avoid playing with messy things | <input type="checkbox"/> Tolerate teeth brushing |
| <input type="checkbox"/> Dislike bathing | <input type="checkbox"/> Discriminate odors |
| <input type="checkbox"/> Object to being touched | <input type="checkbox"/> Chew on non-food substances |
| <input type="checkbox"/> Avoid using hands | <input type="checkbox"/> React negatively to smell |
| <input type="checkbox"/> Appear to be irritated by certain clothing | <input type="checkbox"/> Explore by smelling |
| <input type="checkbox"/> Overreact to having his/her face washed | <input type="checkbox"/> Act as though all foods taste the same |
| <input type="checkbox"/> Have trouble being close to others | |

BODY AWARENESS (proprioception)

Does your child exhibit any of the following? (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Hold his/her hands in a strange position | <input type="checkbox"/> Drop things or bump into things frequently |
| <input type="checkbox"/> Unintentionally push/hit others when intending to express affection | <input type="checkbox"/> Unintentionally break things/toys |
| <input type="checkbox"/> Have difficult assuming or sustaining a grasp on a pencil or crayon | <input type="checkbox"/> Have difficulty drawing or with handwriting |

MOVEMENT & BALANCE (vestibular)

Does your child exhibit any of the following? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Rock himself/herself | <input type="checkbox"/> Squat to stand or jump up from the floor |
| <input type="checkbox"/> Jump excessively | <input type="checkbox"/> Hop on one foot |
| <input type="checkbox"/> Get car sick | <input type="checkbox"/> Catch a ball |
| <input type="checkbox"/> Avoid movement activities | <input type="checkbox"/> Throw a ball |
| <input type="checkbox"/> Appear to have good balance | <input type="checkbox"/> Kick a ball |
| <input type="checkbox"/> Like being tossed in the air | <input type="checkbox"/> Walk on his/her toes |
| <input type="checkbox"/> Like merry go rounds or spinning | <input type="checkbox"/> Have difficulty cutting |
| <input type="checkbox"/> Show fear of playground equipment | <input type="checkbox"/> Hold a pencil in a 3-point grasp |
| <input type="checkbox"/> Prefer seated activities and appear reluctant in playground participation | <input type="checkbox"/> Have trouble walking up/down stairs |
| <input type="checkbox"/> Prefer to play in the house rather than on the playground with other children | <input type="checkbox"/> Have difficulty hopping, jumping, or running |

Comments: _____

SPEECH AND LANGUAGE

What is the primary language spoken in the home?

Are there any other languages spoken in the home? (If so, which one(s))

How does your child usually let you know what he/she wants? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Cries | <input type="checkbox"/> Makes different sounds |
| <input type="checkbox"/> Grunts | <input type="checkbox"/> Uses a few words says two or three word combinations |
| <input type="checkbox"/> Points | <input type="checkbox"/> Uses long sentences |
| <input type="checkbox"/> Uses gestures | |

What does your child do when he/she needs help with something?

What happens if you can't figure out what your child is asking for? What does your child do?

When talking to your child, how much does he/she understand? (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Non-responsive | <input type="checkbox"/> Many words and phrases | <input type="checkbox"/> Almost everything |
| <input type="checkbox"/> A few words | | <input type="checkbox"/> Everything I say |

Can your child usually follow: 1 step directions 2 step directions 3 step directions (Circle one)

At what age did your child?

____ Use single words

____ Two word sentences

____ Complex sentence

Does anyone in your family talk for your child or interpret his/her speech/gestures?

Can people outside your family understand your child's speech?

Did your child's speech and language develop and then seem to stop?

Does your child sometimes speak phrases heard in the past, yet repeat them out of context?

HEARING (SKIP IF NO CONCERN)

Do you suspect a hearing problem?

Has your child had surgery to place tubes in the ears? If so, when? How old? Currently in ears? Y N

Does your child talk in a loud voice or turn up the volume on the TV/radio?

Has your child had a hearing test? If so, when and what were the results?

FEEDING (SKIP IF NO CONCERN)

Do you have any concerns regarding feeding/swallowing?

Has your child ever required supplemental nutrition via NG/G feeding tube or intravenous?

Did/Does your child nurse? How long? Why discontinued?

Did/Does your child take a bottle? How long? Why discontinued?

Does your child have swallowing problems?

Has your child ever had a swallow study? If so, when, where, and what were the results?

How do you currently feed your child?

____ totally by mouth

____ both: mouth and NG/G feeding tube

____ breast only

____ baby food

____ totally by NG/G tube

____ bottle only

____ table food

If bottle fed, at what age did your child stop using the bottle?

What types of foods are the easiest for your child to eat?

What types are your child's favorite foods?

What foods/type of foods does your child refuse? Do fluids leak through your child's nose when drinking?

Did/Does your child use a sippy cup? At what age did they stop?

NON-ORAL FEEDING (SKIP IF NO CONCERN OR CHILD OVER AGE 5)

Type of formula fed and amount per feeding per day:

Did/Does your child suck his/her thumb? When did he/she stop?

Did/Does your child use a pacifier? When did he/she stop?

How long does it take your child to eat/feed at each meal?

Does your child have **difficulty** eating certain textures of food? **(Check all that apply)**

- soft foods
- pureed foods
- chewy foods
- crunchy foods

Where does your child eat? (Check all that apply)

- High chair
- Kitchen table
- Booster seat
- Lying down
- Lap
- Couch/floor
- Other: _____

How does your child indicate to you that (s)he is hungry? If yes, check all that apply.

- Wake up
- Cries and/or screams
- Points
- Says words that means food
- My child does not act hungry

Did/Does your child exhibit any of the following? (check all that apply)

- Drooling
- Gagging
- Vomiting
- Retching
- Difficulty chewing
- Difficulty swallowing
- Trouble breathing while eating
- Difficulty latching on to the nipple
- Food allergies

SOCIAL-EMOTIONAL

YES NO

- Does your child attend to an activity for 10-15 minutes?.....
- Does your child play independently?
- Does your child demonstrate frequent mood changes?
- Does your child separate easily from you?.....
- Does your child have difficulty changing tasks/activities?.....
- Is your child easy to discipline?.....
- Is your child easily frustrated?
- Does your child share toys with others?
- Does your child play with other children?
- Does your child play with adults?.....
- Does your child play with pets?.....

What kinds of toys does your child play with most often?

Does your family have any religious or cultural beliefs that would affect therapy for your child?

Please describe any major life stresses your child has experienced (e.g. death of a loved one, severe illness/disability in the family, divorce, etc...) What age was your child when the stressor occurred?

Has your child seen or experienced any kind of verbal, physical, sexual abuse or violence? If yes, please explain.

Is there any additional information that would help us to better understand your child and/or your concerns?

Briefly describe how your child's behavior would be affected if.....

1.) You asked him/her to perform a difficult task.

2.) You interrupted a desired activity, such as eating ice-cream or watching TV?

3.) You unexpectedly changed his or her typical routine or schedule of activities?

4.) She or he wanted something but wasn't able to get it (e.g., a food item up on a shelf)?

5.) You didn't pay attention to the person or left him or her alone for a period of time?

What are things your child likes and are reinforcing for him or her?

1.) Food Items:

2.) Items/Toys/Objects/Devices:

3.) Activities at Home:

4.) Activities in the Community:

Other:



AUTHORIZATION AND CONSENT FOR TREATMENT

I consent to and grant permission to the employees of Baby Steps Therapy, Inc. to render to my child routine clinical care including evaluations, educational services, and therapy activities/procedures during my receipt of services, and to carry out the orders of my child's physician, including consultants, associates and assistants of his/her choice. I also acknowledge that Baby Steps Therapy, Inc. has not made any guarantee or warranty as to the results of any services or treatments given.

Initials

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Baby Steps Therapy, Inc. to furnish and release medical information to my private insurance carrier, or other third party payer, as may be required for the determination of benefits payable. Respecting my privacy and anonymity, I understand that my child's records may be reviewed for statistical purposes. I grant permission for Baby Steps Therapy, Inc. to communicate all aspects of my child's care with the physician(s) whom I have identified.

Initials

CLINIC OBSERVATION POLICY DISCLOSURE

Baby Steps Therapy utilizes a multi-disciplinary approach to services. We periodically request other personnel from our team to observe and give input. This team may consist of licensed School Psychologists, Behavioral Analysts, speech pathologists, occupational therapists and or student interns. You will always be informed and asked for consent prior to your child being observed.

Initials

VALUABLES

I understand that Baby Steps Therapy, Inc. does not assume responsibility for personal property brought to or left at the facility. I have been advised to leave personal property at home, unless specifically requested by a therapist to assist in my child's treatment.

Initials

PHOTOGRAPHY/VIDEO RELEASE AND DISCLOSURE

I do / do not (circle one) give consent for Baby Steps Therapy, Inc. to take photographs and /or video for clinical, educational, and/or celebratory purposes. **(Baby Steps Therapy does not allow parental AUDIO OR VIDEO RECORDING OF ANY TYPE EITHER WITH SMART-PHONE, I PAD OR OTHER DEVICE).**

PLEASE NOTE ALL IN-HOME SUREVILLANCE SYSTEMS MUST BE DISCLOSED PRIOR TO ANY IN-HOME SERVICES TAKING PLACE.

Initials

OVER DUE ACCOUNTS

Account balances must be paid within (30) days of the date billed. A due date will appear at the bottom of the invoice; if other arrangements have not been made, the credit card on file will be charged the balance due. If the credit card on file is refused you will be sent a follow-up reminder notice of payment due. After (90) days, the account will be turned over to collections.

Initials



CANCELLATION AND LATE POLICIES

Baby Steps Therapy’s mission is to improve the quality of life for as many children as we can. Weekly treatment is necessary to make a real difference for your child. We enforce a strict attendance policy for that reason. We expect that you are as committed to your child’s therapy as we are. If you do not maintain consistent attendance, it may become necessary for us to put your child’s treatment on hold and give your treatment spot to another waiting child who can come on a consistent basis.

Because of our strong commitment to your children, we have a strict attendance/cancellation policy:

If you cancel your appointment with late notice, (less than 48 hours), you will be charged a \$25 fee for the first occurrence. This fee must be paid prior to your child being seen for a subsequent appointment. Second late notice cancellations will be charged a \$50 fee.

If you miss an appointment without calling us, your child will be removed from the schedule and his/her spot will be given to the next child on the waiting list. If your child’s spot is still available, there will be a \$30 reinstatement fee if you want your child rescheduled at our clinic.

No shows/no calls impact our ability as a not-for-profit clinic to remain viable and provide services. We reserve a weekly time slot for your child’s therapy; slots that go unused are not billable and we are not able to rebook appointments without at least 48 hours’ notice.

I understand that if I leave the clinic I am expected to return 15 minutes before the end of the session. I also understand that the treatment session will end at the scheduled time, regardless of my late arrival. (OT sessions are a 50 minute clinical hour, and speech sessions are typically a 25 minute clinical half hour. Confirm with your therapist the actual time needed for your return if you leave the clinic during your child’s appointment).

_____ (initials)

SICK POLICY

Baby Steps Therapy has a strictly enforced sick policy to protect the health of our therapists and other children in the clinic. If your child has or has had a fever, runny nose with colored discharge or a persistent cough in the last 24 hours, we will not see your child. Please call us to reschedule your appointment.

Initials

CERTIFICATION

I certify that any and all information given by me to Baby Steps Therapy, Inc. is correct, to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire. I have read this form (or it has been read to me) and I certify that I understand and agree to all of its conditions.

Signature

Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

Patient’s Name: _____

Date of Birth: _____

Baby Steps Therapy, Inc. **Notice of Privacy Practices** describes in detail how your child's health information may be used and disclosed and explains how you can access your child's information. A copy of the Notice of Privacy Practices has been provided to me.

Patient / Authorized Representative

Date _____

Relationship to Patient _____

INSURANCE

I understand that all co-pays, deductibles, and co-insurance are due at the time of service. If I am unable to provide Baby Steps Therapy, Inc. with my current insurance information prior to my child's appointment, I will pay in full for that day's visit. I agree that I am responsible for knowing and understanding my insurance benefits as they relate to therapy services. I understand that the benefits stated by my insurance company are not a guarantee of payment or coverage, and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that specific therapy charges are incurred at each appointment. I understand that I am fully responsible for all charges for services and/or treatment rendered, and I further agree that all amounts are due upon request and are payable to Baby Steps Therapy, Inc. I will provide Baby Steps Therapy, Inc. with a copy of my insurance card each time I receive a new card and/or my insurance information changes. I understand that if my insurance company delays payment or is waiting on additional information from me before they render payment, and the balance is past 45 days, the balance is my responsibility and is due immediately.

Initials

INSURANCE NOTICE-MUST BE COMPLETED (FOR KAISER AND TRICARE DISREGARD)

All parents are expected to know and understand their coverage and benefits for therapy services. You can verify your benefits by calling the phone number on your insurance card and asking a representative from your insurance company. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits.

- I have called my insurance company to confirm benefits for:
 - OT _____ or
 - Speech therapy _____. (Check one)
- My annual deductible is \$ _____.
- My out of pocket per visit is \$ _____ or _____ %.
- I understand I am liable for the difference between the covered amount and the total fee charged if my insurance company is out of network. _____ (initials).
- Please remember that your insurance policy is between you and your insurance company. A quote of benefits from your insurance company is not a guarantee of payment.
- In the event your insurance chooses not to pay for services, you are responsible for all charges.
- It is illegal for our company to waive the co pay portion of your responsibility. Co- payments are due at the start of each session. We accept check or credit card.

Authorized Signature _____ Date _____

Relationship to patient _____