NEW PATIENT PACKET

6960 Destiny Drive, Suite 112
Rocklin, CA 95677
Phone: (916) 415-0119
Fax: (916) 415-0120

www.BabyStepsTherapy.com

Baby Steps THERAPY

Today's Date: _____/_______/_____

Date of Birth: _____/______/_______ **Age:** _______________ **Gender:** ___________

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 # ____

Baby Steps THERAPY

PRIMARY INSURANCE INFORMATION:

Insurance Subscriber's Name: ____**DOB of Subscriber**_____________________

Name of Insurance Company_________________________________ **Provider Phone number for Insurance**: _____________

Effective Date: ____ **ID or SSN #** ___________________________________

SECONDARY INSURANCE INFORMATION:

Insurance Subscriber's Name: ____**DOB of Subscriber**____________________

Name of Insurance Company________________________________ **Provider Phone number for Insurance**: _____________

Effective Date: ____ **ID or SSN #** __________________________________

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 (why are you coming in for evaluation/treatment):

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: ____

____

 Parent Initials: _____

BabySteps THERAPY

GENERAL HEALTH:

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

- ☐ Allergies
- ☐ Attention Disorder
- ☐ Arthritis
- ☐ Autism/Pervasive Developmental Disorder
- ☐ Chronic Ear Infections
- ☐ Asperger's Syndrome
- ☐ Nerve Injury
- ☐ High Fevers
- ☐ Speech/Language Delay
- ☐ Auditory Processing Disorder
- ☐ Congenital Disorder
- ☐ Meningitis
- ☐ Heart Disease
- ☐ Developmental Delay
- ☐ Orthopedic Injuries
- ☐ Brain Injury
- ☐ Cerebral Palsy
- ☐ Sensory Processing Disorder
- ☐ Seizures
- ☐ Other Behavioral/Psychological Disorder
- ☐ Learning Disorder
- ☐ Diabetes
- ☐ Enuresis/Encopresis
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Obsessive- Compulsive 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)

- ☐ Assisted Delivery
- ☐ Respiratory difficulties
- ☐ Cesarean Section
- ☐ Transfusions
- ☐ NICU
- ☐ Congenital Defects
- ☐ Feeding Diifficulties (sucking, swallowing)
- ☐ Tube Feeding
- ☐ Hypotonia
- ☐ Need for oxygen
- ☐ Supplemental nutrition
- ☐ Jaundice
- ☐ Breech

BabySteps THERAPY

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

_____ Bathing	_____ Eating	_____ Shoes	_____ Drinking
_____ Brushing Hair	_____ Finger Foods	_____ Socks	_____ Open Cup
_____ Brushing Teeth	_____ Utensils	_____ Shirt	_____ Straw
_____ Dressing	_____ Fork	_____ Tie Shoes	_____ Sippy Cup
_____ Pants	_____ Spoon	_____ Buttoning	_____ Toileting
_____ Zipping	_____ Snapping Clothing	_____ Snapping Fingers	

Additional Comments: ____

PLEASE LIST THE TYPES OF THERAPIES YOUR CHILD HAS PREVIOUSLY HAD OR IS CURRENTLY RECEIVING (NOT INCLUDING US):

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)

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

Additional Comments: ____

____

____

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

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

BODY AWARENESS (***proprioception***)
Does your child exhibit any of the following? (Check all that apply):

_____ Hold his/her hands in a strange position	_____ Drop things or bump into things frequently
_____ Unintentionally push/hit others when intending to express affection	_____ Unintentionally break things/toys
_____ Have difficult assuming or sustaining a grasp on a pencil or crayon	_____ Have difficulty drawing or with handwriting

 Parent Initials: _____

Baby Steps THERAPY

MOVEMENT & BALANCE **(vestibular)**
Does your child exhibit any of the following? (Check all that apply):

____ Rock himself/herself
____ Jump Excessively
____ Get car sick
____ Avoid movement activities
____ Appear to have a good balance
____ Like being tossed in the air
____ Like Merry go rounds or spinning
____ Show fear of playground equipment
____ Prefer seated activities and appear reluctant in playground participation
____ Prefer to play in the house rather than on the playground with other children
____ Squat to stand or jump up from the floor
____ Hop on one foot
____ Catch a ball
____ Throw a ball
____ Kick a ball
____ Walk on his/her toes
____ Have difficulty cutting
____ Hold a pencil in a 3-point grasp
____ Have trouble walking up/down stairs
____ 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)
_____ Cries
_____ Grunts
_____ Points
_____ Uses gestures
_____ Makes different sounds
_____ Uses a few words says two or three word combinations
_____ Uses long sentences

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)
_____ Non-responsive
_____ A few words
_____ Many words and phrases
_____ Almost everything
_____ Everything I Say

Can your child usually follow (Circle one): 1 Step Directions 2 Step Directions 3 Step Directions

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 IN 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
_____ totally by NG/G tube
_____ both: mouth and NG/G feeding tube
_____ breast only
_____ bottle only
_____ baby food
_____ 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?

Baby Steps THERAPY

CONTINUED: **NON ORAL FEEDING**

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? (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?

 Parent Initials: _____

Baby Steps THERAPY

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 of 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:

____
____
____

 Parent Initials: _____

Baby Steps THERAPY

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, Physical 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: _______

CREDIT CARD ON FILE

I understand that **all patients must have a credit card on file** with Baby Steps Therapy. This card will not be run without first notifying you of the charge. Baby Steps Therapy stores all card information securely with only the access to the last four digits. I have provided this information on **the last page of this packet**.

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: _______

SERVICE ANIMALS

Baby Steps will allow a service animal to accompany the service animal's partner/handler at all times in all areas of the clinic that are unrestricted to clients of the clinic, provided the presence of the animal does not pose a direct threat, or result in a fundamental alteration of the nature of a program or service provided by the Clinic.
In the event that the service animal's presence or conduct gives rise to a health or safety concern, the clinic will first establish whether, in the opinion of a qualified medical professional, the animal presents a direct threat to the health or safety of others. **If you will be or think you will be bringing a service animal to the clinic, please disclose this information to office staff prior to the first visit.**

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 (if clinically recommended) 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, we reserve the right to dismiss your child from therapy.

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 business hours), regardless of reason, you will be charged a $50 fee per session per occurrence for any non-rescheduled appointment. This fee must be paid at the time of cancellation. If you are unable to attend the rescheduled session for any reason, you will be subject to the cancellation charge.

We understand that unforeseen events may impact your child's ability to attend their scheduled session. All families have one free late cancellation per calendar year.

*****If you do not consistently complete 80% of your child's scheduled, reserved appointment slots, your slot will be forfeited. Research has shown that consistent, ongoing parent participation improves the outcomes of therapy. We expect parents to be involved and to commit to a minimum 6-month time period of weekly therapy.**

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 business 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 ___________

WAITING ROOM POLICY

Baby Steps Therapy's front waiting room is a working area for staff. Because of this, we have a strict no cell phone and no food rule. I understand that if I am using my cell phone or eating, I will be asked to go outside.

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.

_______________________________________ Date__________________
Patient / Authorized Representative

Relationship to Patient: ____

Baby Steps THERAPY

INSURANCE

I understand that all co-pays, deductibles, and co-insurance are due at the time of service. 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 reimbursements are related to 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

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:

- **Occupational Therapy (OT) ______ Speech therapy (ST) ______ Physical therapy (PT) ______. (Check one)**
- **My annual deductible is $_______________ Applicable to this therapy? Y N**
- **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.**
- **Co- payments are due at the start of each session. We accept check or credit card.**

Authorized Signature____ Date ______________________

Relationship to patient____

BabySteps THERAPY

Patient Credit Card Information

Printed Name (as is appears on your card): ____

Card Number: ____

Expiration Date (MM/YYYY or MM/DD/YYYY format): _______________

Security Code: ______________

Billing Zip-Code: _____________

 Parent Initials: _____