NEW PATIENT PACKET

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www.BabyStepsTherapy.com

Baby Steps THERAPY
A PLACE TO GROW.

Today's Date: _____/_______/_____

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

Patient's last name: _______________________________________ First: ______________________________ M.I._____________

Who referred you to us? ____

RESPONSIBLE PARTY

Name: ____ Relationship to Patient: ______________________________

Cell Phone: (_________) _________ ---____________ E-mail Address: ____

Street Address: ____ Patient's Primary Address Y / N

City: ____ State: ______________________ Zip: _________________

Name: ____ Relationship to Patient: ______________________________

Cell Phone: (_________) _________ ---____________ E-mail Address: ____

Street Address (☐same as above): ____ Patient's Primary Address Y / N

City: ____ State: ______________________ Zip: __________________

EMERGENCY CONTACT (Other than above)

Name: ____ Relationship to Patient: _______________________________

Cell Phone: (_________) _________ ---____________

CUSTODY AND LIVING ARRANGEMENTS

With whom does the patient reside? ☐Both Parents ☐ Mother Only ☐ Father Only ☐ Split Custody ☐ Other:____________________

If split custody, please describe: ____

____

List siblings living with the patient: (Names and ages) ____

Please list any other information about the patient'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 the patient's therapy, I am obligated to notify Baby Steps Therapy, Inc. immediately.

Signature: ____ Date: _______________

Relationship to Patient: _________________________________

Name of patient's primary doctor: ____

Office Address: ____

Phone # ____ Fax # ____

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PRIMARY INSURANCE INFORMATION (If applicable)

Insurance Subscriber's Name: ____DOB of Subscriber: _____________________

Name of Insurance Company: __________________________________ Provider Phone number for Insurance: __________________

Effective Date: ____ ID or SSN #: ____

SECONDARY INSURANCE INFORMATION (If applicable)

Insurance Subscriber's Name: ____DOB of Subscriber: _____________________

Name of Insurance Company: __________________________________ Provider Phone number for Insurance: __________________

Effective Date: ____ ID or SSN #: ____

Does the patient have Medi-Cal? Y / N (Please note- Baby Steps Therapy, Inc. is **not** a Medi-Cal provider)

MEDICAL HISTORY

Does the patient have any diagnoses? Y / N If yes, please state: ____

Does anyone in the patient's family have a related diagnosis? Y / N If yes, whom and what diagnosis? ________________________

____

Has the patient ever been on a long-term program of medication? Y / N If yes, please explain: _______________________________

____

What are the patient's current medications and regimen? ☐ N/A ____

____

Allergies? Y / N If yes, please explain: ____

Has the patient ever had a bad or unusual reaction to any food or drug? Y / N If yes, please explain: ________________________

____

Does the patient see any other physicians / specialists Y / N If yes, please explain: ______________________________________

List any previous medical/surgical procedure and/or hospitalizations (include date and explain): ☐ N/A __________________________

____

Has the patient ever been exposed to a contagious illness or required contact isolation (CMV, MRSA,TB)? Y / N

If yes, please explain: ____

PREGNANCY AND BIRTH HISTORY

Patient's birth weight: _______________________ Born at how many weeks' gestation? _________________________________

Any medications taking during pregnancy? Y / N If yes, please list: ____

Alcohol or drugs used during pregnancy? Y / N If yes, please explain: ____

Complications during pregnancy? Y / N If yes, please explain: ____

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

- ☐ Assisted Delivery
- ☐ Breech
- ☐ Cesarean Section
- ☐ Congenital Defects
- ☐ Hypotonia
- ☐ Jaundice
- ☐ Need for oxygen
- ☐ NICU/PICU (length of stay:___________)
- ☐ Supplemental nutrition
- ☐ Transfusions
- ☐ Tube Feeding

 Guardian Initials: _________

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☐ Feeding Difficulties (sucking, swallowing) ☐ Respiratory difficulties

DEVELOPMENTAL HISTORY (Please skip if the patient is over age 5)

At what age did the patient: (If unsure of exact ages, please note whether each milestone was early (E), on-time (O) or delayed (D))

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

Additional Comments: ____

____

GENERAL HEALTH

Has the patient been diagnosed with or had any of the following: (Check all that apply)

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

Comments: ____

HEARING

Do you suspect a hearing problem? Y / N If yes, please explain: ___________________________________

Has the patient had surgery to place tubes in the ears? Y / N If yes, when? __________ How old? _______ Currently in ears? Y / N

Does the patient talk in a loud voice or turn up the volume on the TV/radio? Y / N

Has the patient had a hearing test? Y / N If yes, when ____________ and what were the results? __________________

SLEEP

How many hours does the patient nap each day? ____________ How many hours does the patient sleep at night? ______________

Do you have concerns regarding the patient's sleep? Y / N

If yes, please check all that apply:
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficult to rouse in the morning
☐ Other: ____________________________

EDUCATION

School patient currently attends: _______________________________________ Location: _____________________________

Grade: _______________

School Schedule

	Mon	Tues	Wed	Thurs	Fri	Sat/Sun
Start Time:	_________	_________	_________	_________	_________	_________
End Time:	_________	_________	_________	_________	_________	_________

Does the patient participate in recreational activities? Y / N If yes, describe: ____

PREVIOUS OR CURRENT THERAPIES (Not including Baby Steps Therapy, Inc. or ABA in Action) ☐ N/A

1. Type: ____ From:_________________ To:____________________

   Location: ____

   If currently receiving, days/times: ____

2. Type: ____ From:_________________ To:____________________

   Location: ____

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If currently receiving, days/times: ____

BEHAVIOR AND PARTICIPATION

Briefly describe how the patient's behavior would be affected if…

You asked him/her to perform a difficult task: ____
____

You interrupted a desired activity, such as eating ice-cream or watching TV: ____
____

You unexpectedly changed his/her typical routine or schedule of activities: ____
____

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

You didn't pay attention to the patient or left him/her alone for a short period of time: ____
____

What are things the patient likes and are reinforcing for him/her?

Food items: ____
____

Items/Toys/Objects/Devices: ____
____

Activities at home: ____
____

Activities in the community/school: ____
____

Other: ____
____

SELF HELP SKILLS

Mark "I" for Independent, "N" for Needs Help

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

Additional Comments: ____

SENSORY

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

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

BODY AWARENESS

Does the patient exhibit any of the following? (Check all that apply):

_____ Drop things or bump into things frequently
_____ Have difficult assuming or sustaining a grasp on a pencil or crayon
_____ Hold his/her hands in a strange position
_____ Unintentionally break things/toys

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_____ Have difficulty drawing or with handwriting

_____ Unintentionally push/hit others when intending to express affection

MOVEMENT & BALANCE

Does the patient exhibit any of the following? (Check all that apply):

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

Comments: ____

SPEECH AND LANGUAGE

What is the patient's primary language? ____

Are there any other languages spoken in the home? Y / N If yes, which one(s): ____________________________

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

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

Can the patient usually follow (Check one): _____ 1-Step Directions _____ 2-Step Directions _____ 3-Step Directions

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

_____ Cries
_____ Grunts
_____ Makes different sounds
_____ Points
_____ Uses a few words says two or three-word combinations
_____ Uses gestures
_____ Uses long sentences

What does the patient do when she/he needs help with something? ______________________________________

What happens if you can't figure out what the patient is asking for? ______________________________________

At what age did the patient?

_____ Use Single Words _____ Two Word Sentences _____ Complex sentence

Does anyone in your family talk for the patient or interpret his/her speech/gestures? Y / N

Can people outside your family understand the patient's speech? Y / N

Did the patient's speech and language develop and then seem to stop? Y / N

Does the patient sometimes speak phrases heard in the past, yet repeat them out of context? Y / N

SOCIAL- EMOTIONAL

Does the patient separate easily from you? Y / N

Is the patient easily frustrated? Y / N

Does the patient understand others perspectives when problems arise? Y / N

Does the patient ask questions or engage in conversation? Y / N

How long does the patient attend to a preferred activity? ____

How does the patient play independently? ____

How does the patient play/engage with other children? ____

How does the patient play with adults? ____

How does the patient get your attention? ____

Does your family have any religious or cultural beliefs that would affect therapy for the patient? Y / N If yes, please explain: _______
____

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SOCIAL- EMOTIONAL *(continued)*

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

Has the patient seen or experienced any kind of verbal, physical, sexual abuse or violence? Y / N If yes, please explain: _________
____

Is there any additional information that would help us to better understand the patient and/or your concerns in regards to the patient's social-emotional health? ____
____

FEEDING (skip if no concern)

Did/Does the patient suck his/her thumb? Y / N If yes, when did he/she stop? _________________

Did/Does the patient use a pacifier? Y / N If yes, when did he/she stop? _____________________

How long does it take the patient to eat/feed at each meal? _________________________________

Do you have any concerns regarding feeding/swallowing? Y / N If yes, please explain: ___________________________________

Has the patient ever required supplemental nutrition via NG/G feeding tube or intravenous? Y / N

Did/Does the patient breastfeed? Y / N If yes, how long? ______________ Why discontinued? __________________________

Did/Does the patient take a bottle? Y / N If yes, how long? ______________ Why discontinued? __________________________

Did/Does the patient use a sippy cup? Y / N If yes, how long? ______________ Why discontinued? ________________________

Has the patient ever had a swallow study? Y / N If yes, When? __________________ Where? ___________________________

What were the results? ____

How do you currently feed the patient? (Check all that apply)
_____ baby food _____ breast only _____ entirely by mouth
_____ bottle only _____ table food _____ entirely by NG/G tube

What types of foods are the easiest for the patient to eat? ____

What types are the patient's favorite foods? ____

What foods/type of foods does the patient refuse? ____

Does the patient have **difficulty** eating certain textures of food? (Check all that apply)
_____ Chewy foods _____ Soft foods _____ Crunchy foods _____ Pureed foods

Where does the patient eat? (Check all that apply)
_____ Booster seat
_____ Couch/floor
_____ High Chair
_____ Kitchen table
_____ Lap
_____ Lying down
_____ Other: __________________________

How does the patient indicate to you that she/he is hungry? (Check all that apply)
_____ Cries and/or screams
_____ The patient does not act hungry
_____ Points
_____ Says words that means food
_____ Wake up
_____ Other: _________________________

Did/Does the patient exhibit any of the following? (Check all that apply)
_____ Difficulty chewing
_____ Difficulty latching on to the nipple
_____ Difficulty swallowing
_____ Drooling
_____ Gagging
_____ Retching
_____ Trouble breathing while eating
_____ Vomiting

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AUTHORIZATION AND CONSENT FOR TREATMENT

I consent to and grant permission to the employees of Baby Steps Therapy, Inc. to render to the patient routine clinical care including evaluations, educational services, and therapy activities/procedures during my receipt of services, and to carry out the orders of the patient'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.

The patient/guardian(s) and the clinician have the right, at any point, to terminate services. Termination of services may occur for the following reasons:

- No / limited functional progress is made toward current goals
- Patient/family unable to complete home practice
- Patient/family does not participate or attend therapy services per policy
- Standardized assessment scores and/or informal assessment suggest that skilled therapy is no longer necessary

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 the patient's records may be reviewed for statistical purposes. I grant permission for Baby Steps Therapy, Inc. to communicate all aspects of the patient's care with the physician(s) whom I have identified.

Initials: _______

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I give my consent for the staff of Baby Steps Therapy, Inc. to administer emergency medical treatment (including but not limited to bandages, icepacks, etc.), as well as to contact any deemed necessary medical provider to provide further medical treatment as needed for the patient. I understand that this may include calling an ambulance and therefore result in ambulance transfer fees. I understand and agree that I will not hold Baby Steps Therapy, Inc. responsible for such fees.

Initials: _______

CLINIC OBSERVATION POLICY DISCLOSURE

Baby Steps Therapy, Inc. 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-Language Pathologists, Occupational Therapists, Physical Therapists, Assistants, and/or student interns. You will be informed and asked for consent prior to the patient 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 the patient'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, Inc. does not allow outside audio or video recording of any type either with smart-phone, iPad, or other device (including but not limited to guardians, outside providers, siblings, etc.).**

Initials: _______

CREDIT CARD ON FILE

I understand that **all patients must have a credit card on file** with Baby Steps Therapy, Inc.. This card will not be charged without first notifying you of the charge. Baby Steps Therapy, Inc. 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: _______

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SERVICE ANIMALS

Baby Steps Therapy, Inc. 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 Baby Steps Therapy, Inc.
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, Inc.'s mission is to improve the quality of life for as many patients as we can. Weekly treatment (if clinically recommended) is necessary to make a real difference for the patient. We enforce a strict attendance policy for that reason. We expect that you are as committed to the patient's therapy as we are. If you do not maintain consistent attendance, we reserve the right to dismiss the patient from therapy.

Because of our strong commitment to our patients, 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 the patient'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 the patient's scheduled, reserved appointment slots, their timeslot will be forfeited. Research has shown that consistent, ongoing guardian participation improves the outcomes of therapy. We expect guardians to be involved and to commit to a minimum 6-month time period of weekly therapy (if recommended).**

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 the patient'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 and PT 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 the patient's appointment).

Initials ___________

SICK POLICY

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

Initials ___________

WAITING ROOM POLICY

Baby Steps Therapy Inc.'s front waiting room is a working area for staff. Because of this, we have a strict no cell phone and no food policy. 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.

_________________________	_________________________	____________
Guardian Signature	Printed Name	Date

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Patient's Name: ____ Date of Birth: _________________________

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

____ _____________________________________ _______________
Guardian Signature Printed Name Date

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 if utilizing insurance)

All guardians 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-Language Therapy (ST) ____ Physical Therapy (PT) ____ (Check one)
- The patient's annual individual deductible is $_______________ Applicable to this therapy? Y / N
- The family's annual deductible is $_______________ Applicable to this therapy? Y / N
- The patient's annual maximum out of pocket (MOOP) is $_______________
- The family's annual maximum out of pocket (MOOP) 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 my insurance chooses not to pay for services, I understand I am responsible for all charges. ______ (initials)**
- Co- payments are due at the start of each session. We accept cash (exact change), check or credit card.

Authorized Signature____ Date ______________________

Relationship to patient____

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Patient Credit Card Information

This information can be brought to the first session rather than sent prior, however, it must be given prior to the first session beginning.

Patient's Name: ____

Card Holder's Name (as is appears on the card): ____

Card Number: ____

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

Security Code: ______________

Billing Zip-Code: _____________

This card is an HSA/Flex Spending: Y / N