LEAPS & BOUNDS
PEDIATRIC THERAPY

PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Last Name:____________ First Name:____________ Middle I:______

Current Address:________________________

City:____________ State:________ ZIP Code:________

Date of Birth:____/____/____

Gender: M ☐ F ☐

Height:______ Weight:______

Ethnicity:

Caucasian ☐ African American ☐ Hispanic/Latino ☐

Asian/Pacific Islander ☐ Other/Unknown ☐ Decline to answer ☐

PARENT/GUARDIAN INFORMATION

1.Parent/Legal Guardian Last Name:____________ **First Name:**____________ **Middle I:**______

Cell Phone #:____________ Work Phone #:____________

Email:________________________ Single ☐ Married ☐ Divorced ☐

Spouse's Name:____________ Relationship to patient:____________

2.Parent/Legal Guardian Last Name:____________ **First Name:**____________ **Middle I:**______

Cell Phone #:____________ Work Phone #:____________

Email:________________________ Single ☐ Married ☐ Divorced ☐

Spouse's Name:____________ Relationship to patient:____________

INSURANCE INFORMATION

Name of Primary Subscriber:____________ **Subscriber DOB:**____/____/____

Insurance Carrier:____________ **Subscriber #:**____________ **Group #:**________

Phone #:____________ **Fax #:**____________

REFERRAL INFORMATION

Purpose of your visit:________________________

How did you hear about our practice?

Referring Person/Physician:________________________

Former Patient/Friend:________________________

Instagram ☐ Facebook ☐ Website ☐

Other:________________________

CHILD'S HEALTH HISTORY

PREGNANCY & BIRTH HISTORY

Was your child born full term? Yes ☐ No ☐ If no, how many weeks gestation?______________

Were there any extraordinary conditions during the pregnancy? Yes ☐ No ☐

(Examples: High fever, infection, prescription medications, high blood pressure, etc.)

If yes, please describe:____

Were there any extraordinary conditions during or after the birth? (ex: NICU stay, oxygen) Yes ☐ No ☐

If yes, please describe:____

CHILD'S HEALTH HISTORY

Does your child have a medical diagnosis? Yes ☐ No ☐

If yes, please describe:____

Has your child's hearing been tested? Pass ☐ Fail ☐

Has your child's vision been tested? Pass ☐ Fail ☐

Does your child have a history of ear infections? Yes ☐ No ☐

Does your child have any allergies? Yes ☐ No ☐

If yes, please describe:____

Has your child had any hospitalizations? Yes ☐ No ☐

If yes, please describe:____

Has your child had any surgeries? Yes ☐ No ☐

If yes, please describe:____

Are your child's immunizations current? Yes ☐ No ☐

Is your child taking any medication? Yes ☐ No ☐

If yes, please list:____

____

____

____

____

CHILD'S HEALTH HISTORY

CHILD'S HEALTH HISTORY

What language is primarily spoken in the home? ______________________________

What are your concerns about your child? (Ex. Difficulty dressing, picky eating, walking down stairs, using speech sounds correctly) ______________________________

____

____

____

____

Is your child receiving services currently?

IRC ☐ ABA ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐

If so, where: ______________________________

____

Has your child received services in the past?

IRC ☐ ABA ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐

If so, where: ______________________________

____

I, the undersigned, declare that the above information is true and accurate. I assign directly to Leaps & Bounds Pediatric Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Leaps & Bounds Pediatric Therapy to release all information necessary to secure the payment of benefits.

______________________________ ______________

Signature of Parent/Legal Guardian/Responsible Party Date

LEAPS & BOUNDS
PEDIATRIC THERAPY

PATIENT PHOTO RELEASE

PHOTO RELEASE

I,____ , give my permission to use my child's name, ______________________________, likeness, image, voice, and/or appearance as such may be embodied in pictures, photos, video recordings, audiotapes, digital images, and the like, take or make on behalf of Leaps & Bounds Pediatric Therapy Inc. I agree that Leaps & Bounds Pediatric Therapy Inc. has complete ownership of such pictures, etc. including the entire copyright and may use them for any purpose consistent with the Leaps & Bounds Pediatric Therapy program mission. I acknowledge that I will not receive any compensation, etc. for the use of these pictures etc. and hereby release Leaps & Bounds Pediatric Therapy Inc. and any of its agents and assigns from any and all claims which arise or are in any way connected with such use.

☐ I give my consent to Leaps & Bounds Pediatric Therapy Inc. to use my name/child's name and likeness to promote the program, its fiscal agent, and/or their activities. I consent to allow use in the following ways:

·Social Media (Facebook & Instagram - @leapspedstherapy)
·Printed Materials (photos, illustrations, bulletins, publications)
·Promotional Material (advertisements, flyers, exhibitions)
·Videos

☐ **I decline use of my child's image, likeness, voice and/or appearance in any way.**

I, the undersigned, declare that the above information is true and accurate.

____ ____________________

Signature of Parent/Legal Guardian/Responsible Party Date

RELEASE OF LIABILITY

All new and current patients must have a signed Release of Liability form on file, should you ever need to reschedule at another location.

OUR NORCO MAIN CAMPUS IS AN EQUINE FACILITY. All activities on the grounds are subject to the Equine Inherent Risk Law. By your presence on these grounds you have indicated that you have accepted the limits of liability resulting from inherent risks of equine activities. THIS IS NOT A SPECTATOR AREA. All persons in this area (visiting 4211 Valley View Ave. in Norco, CA) will be regarded as participants and limited by the INHERENT RISK LAW. This law is strongly supported by The American Horse Council.

This release of liability made and entered into on ____________________, by and between Leaps & Bounds Pediatric Therapy, Inc., and ____. In return for the use, today and on all future dates, of the horses, services, facilities and property of Leaps & Bounds Pediatric Therapy Inc., the rider/patient, his or her parents/guardians, his or hers legal representatives hereby expressly agree the following terms and conditions:

- Rider/patient and parents/guardians has been advised that ASTM (American Society for Testing and Materials) safety approved riding helmets with chin harness is required any time a person is mounted.
- Rider/patient and parents/guardians understands that hippotherapy services require a licensed physical therapist/physical therapist assistant, occupational therapist/occupational therapist assistant and speech language pathologist/speech language pathologist assistant be present during the session.
- Rider/patient and parents/guardians agree to assume all responsibility and risks of injury, death, or property damage from the participation in equestrian activities. Further they agree to hold Leaps & Bounds, its officers, directors, employees, subcontractors, and volunteers free from liability or damages for any injury to person(s) or property damage or loss as a result of this participation.
- Rider/patient and parents/guardians and Leaps & Bounds acknowledge and agree that riding is a dangerous sport and horses are extremely unpredictable and dangerous by nature even if well trained and handled properly.
- It is further agreed by all concerned and involved that every effort is always taken to protect horse and rider/patient from any danger that can be identified.

I, the undersigned, declare that the above information is true and accurate.

____ ____________________

Signature of Parent/Legal Guardian/Responsible Party Date

LEAPS & BOUNDS
PEDIATRIC THERAPY

OFFICE POLICIES

TARDINESS

If you/patient arrives late but within the first 10 minutes, your treatment will end at the scheduled time in order to be respectful of the next patient's time. If you/patient arrives 10 minutes or later, your session will be rescheduled. Typically, approximately 5-10 minutes of your scheduled appointment time will be used for consult with your therapist and cleanup/set up time.

LATE CANCELLATION / NO-SHOW – ZERO TOLERANCE POLICY

It is important to keep any appointments you schedule or contact us as soon as possible if you/patient cannot - this way we can schedule others who wish to receive treatment. We require 24-hour notice if you/patient must cancel or reschedule your/patient's appointment.

- If you/patient fail to attend two appointments consecutively without notifying the front office, your child will be removed from the re-occurring schedule and you/patient will have the option to schedule with our flexible schedule.
- If there is more than one no-show and/or frequent cancellations, your child may be removed from the reoccurring schedule and asked to schedule with our flexible schedule.
- If your child will be absent from their appointments for 2 consecutive weeks, your child may be removed from the schedule, and you will be asked to call back to reschedule once they return from their break.
- We also offer Telehealth session for convenience & flexibility.

CHANGES IN THERAPY TOOLS

You/your child come to us for Physical, Occupational and/or Speech Therapy services. Our therapists use a variety of treatment tools including: the horse, a ball, treadmill, weights, swing, putty, etc. Should they be unable to use one of these tools, your/your child's appointment will remain scheduled. You will be notified if, for any reason, we need to cancel or re-schedule your/your child's session.

SICKNESS

We understand that your child/patient may wake up sick. We would rather you not bring your child/patient into therapy sick to avoid exposing other children or our staff, and to be sure your child/patient is able to participate fully. Also, if your child /patient is too sick to attend school, they should not attend therapy. We ask that you call as soon as possible; the night before, or as soon as you realize they may be ill. Under these circumstances we can waive the late cancellation fee on the 1st occurrence. We ask all patients to wait at least 24 hours after breaking a fever, vomiting or diarrhea before returning to therapy. If your child/patient is well enough, we have the option to see them at their regular appointment time via Telehealth.
COVID-19: We ask that you self-monitor your child/patient for symptoms. If you/your child test positive or are exposed, please contact our front office before returning to your appointments.

RECORDS REQUEST

The clinic provides copies of records as requested electronically. There is no fee for the first 10 pages sent electronically. Fee for 11 pages or more will be $25 for electronic delivery and $35 for printed copies. To request medical records, a request must be submitted in writing to include name, date, all records requested and signature of patient of record's request. The company will provide these records within 30 calendar days. Requests should be submitted to Ashley Beadel at ashley@leapspediatric.org.

CELL PHONE FREE ZONE

All treatment areas are Cell Phone Free Zones. To respect patient privacy, no phones will be allowed out in any treatment space.

CONFLICT OR CONCERN RESOLUTION

Occasionally concerns arise and we want to make them right. Please share your concerns regarding evaluation and treatment directly with your therapist. Our therapists are your partners for success and are here to guide you as part of your child's care team. Our Client Service Representative, Megan Dimsey, is available for any questions or concerns you may have about your experience here at Leaps & Bounds. You can reach Megan at MDimsey@leapspediatric.org. We want you to be happy with our care and feel supported as part of the Leaps Family. We want your child to succeed and grow by leaps and bounds! It's important to us.

LEAPS & BOUNDS
PEDIATRIC THERAPY

PATIENT FINANCIAL POLICIES

Leaps & Bound Pediatric Therapy is sensitive to the high costs involved with therapy services and the variability of insurance coverage. Our practice provides service in good faith with the expectation that they will be paid for. It is our wish that you would have a clear understanding of our Patient Financial Policy and its importance to our working relationship. If you understand your insurance policy and our payment policy, prompt payment and insurance reimbursement for services will be timely.
In order for you to understand your financial responsibility, we ask that you read each statement and initial to show your understanding of the information.

TYPE OF FINANCIAL RESPONSIBILITY

INSURANCE ☐ PRIVATE PAY ☐ SCHOOL SERVICES ☐

(Private Pay clients can skip lines 1-6) (School Service patients can skip lines 1-8)

POLICIES

#	INITIAL	POLICY
1		Your medical insurance policy is a contract between your employer and/or you and the insurance carrier Leaps & Bounds Pediatric Therapy is not a party to the contract.
2		Copayments, coinsurance and other applicable fees are due at the time of service. If payment is not received for services rendered to you/your child in a timely manner, you/your child will be removed from the schedule due to inability to pay patient responsibility and will not be able to resume services until the account balance is paid in full.
3		Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service. **We strongly suggest you call your insurance and obtain benefit information for therapy services to avoid any coverage discrepancies. If there are any differences regarding what has been communicated, please let us know immediately.
4		Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary". Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.
5		Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.
6		You will receive an EOB (Explanation of Benefits) or RA (Remittance Advice) from your insurance company detailing when they have made a payment to us as well as a breakdown for patient responsibility.
7		We accept payment by cash, checks, Mastercard, Visa, American Express, or Discover. If any of your checks are returned/not paid by your bank for any reason, LBPT reserves the right to charge you a handling fee.
8		No itemized receipts will be provided for non-covered or discontinued services. End of year statements must be requested in writing to FrontDesk@leapspediatric.org 2 weeks in advance.

PATIENT CONSENT & RELEASE

I understand that I am financially responsible for all charges for services rendered regardless of litigation, or insurance reimbursement. I understand that the person accompanying a minor will be responsible for payment.

I authorize Leaps & Bounds Pediatric Therapy Inc. to release any necessary information to my insurance carrier and authorize payment directly to Leaps & Bounds Pediatric Therapy Inc. for any therapy benefits available under my insurance plan. I have read and understand the Office and Patient Financial information above.

Signature of Parent/Legal Guardian/Responsible Party ______________________ Date ______________

NOTICE OF PRIVACY PRACTICES

We respect patient confidentiality and only release personal health information about you in accordance with the State and Federal Law. This notice describes how personal health information about you may be used and disclosed. Please review the policies related to use of the records of your care generated by Leaps & Bounds Pediatric Therapy.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Leaps & Bounds Pediatric Therapy. This includes for:

Treatment: With your permission we may use or disclose personal health information about you/your child to provide, coordinate, or manage your/your child's care or any related services, including sharing information with others outside Leaps & Bounds Pediatric Therapy that we are consulting with or referring you to.

Payment: Information will be used to obtain payment for treatment and services provided. This will include contacting your health insurance company for prior approval of plan treatment or for billing purposes.

Healthcare Operations: We may use the information about you to coordinate our business activities. This may include setting up appointments, reviewing your/your child's care, training staff.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you/your child has an appointment for treatment or medical care.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be important to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care: We may release medical information about you/your child to your family member or friend who is involved in your/your child's medical care. The nature of our practice often involves working with families. Your information may be shared with your family members, unless there is a specific written instruction from you to the contrary.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Under STATE and FEDERAL Law, information about you/your child may be disclosed without you/your child's consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care: We may contact you to remind you of future or information about treatment alternatives or other health related benefits and services that may be of interest to you.

As Required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as but not limited to child abuse, spousal abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors: We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purpose of carrying out their duties.

Governmental Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There also might be a need to share information with The Food and Drug Administration related to adverse events or products defects. We are also require to share information, if requested with the Department of Health and Human Services to determine our compliance with Federal Laws related to health care.

Criminal Activity or Danger to Others: If a crime is committed on our premises or against our personnel, we may share information with law enforcement and/or to warn any potential victims when we believe an immediate danger may exist to someone, and/or when we believe your child presents a danger to themselves.

HIPAA

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

1. Please list the telephone numbers and email address, if any, where you want to receive calls or information about your appointments, evaluations or other information related to your/your child's care that would come directly from our office, Leaps & Bounds Pediatric Therapy.

Parent/Legal Guardian:___________________________ **Home Phone #:**___________________

Cell Phone #:________________ **Work Phone #:**_______________ **Other:**_________________

Email:____

Parent/Legal Guardian:___________________________ **Home Phone #:**___________________

Cell Phone #:________________ **Work Phone #:**_______________ **Other:**_________________

Email:____

2. Confidential messages (Ex. Appointments, referrals, insurance information) can be left on home answering machine, cell phone voicemail, email address, etc. (Check all that apply)

Home Phone: ☐ **Cell Phone:** ☐ **Work Phone:** ☐ **Email:** ☐ **Other:** ☐

3. Please list the family members or other persons whom we may discuss your/your child's appointments, treatment sessions, general information with:

Name:________________________________ **Relationship to Patient:**____________________

Name:________________________________ **Relationship to Patient:**____________________

Name:________________________________ **Relationship to Patient:**____________________

4. Please list the Physician that you are working with and would like information (Ex. Initial Evaluations, Re-Assessments, Progress Notes, etc.) sent to:

Primary Care Physician:______________________________ **Phone #:**____________________

Address:____ **Fax #:**____________________

Medical Specialist:__________________________________ **Phone #:**____________________

Address:____ **Fax #:**____________________

5. Please print the address of where you would like all billing statements and/or correspondence from our office to be sent:

Address:____

City:___________________________ **State:**____________________ **Zip:**_______________

The information provided is good for the period of one year from the date it is signed and agreed to by the patient/patients legal guardian. It is the patient/patients legal guardian's responsibility to update this information if the need arises.

Patient Name:_______________________________________ Patient DOB: ______/______/________

____
Signature of Parent/Legal Guardian/Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receiving a copy of Leaps & Bounds Pediatric Therapy Patient Privacy Notice describing my right to privacy of my protected health information (PHI) under the Federal HIPAA privacy Laws:

- How my PHI may be used and disclosed
- My privacy rights regarding my PHI
- The medical practices' obligations concerning the use and disclosure of my PHI.

HIPAA FORM

I have read and understood the HIPAA policy

____
Initial

PATIENT POLICIES

I have read and understood the Patient Policies

____
Initial

I, the undersigned, declare that the above information is true and accurate.

______________________________ ________________
Signature of Parent/Legal Guardian/Responsible Party Date