

When Completed Please Return This Form To:
 6855 W Fairview Ave Ste 120, Boise ID 83704
 (208) 323-8888

Date:

**Children's Therapy Place Inc.
 Client Medical/History Information**

Name:		DOB:	Age:
Address:		SS#:	Medicaid #:
		Healthy Connections#	Ph:
Parent(s)/ Guardian(s):			
Emergency contact:		Ph:	Relation:
School:	Contact:		
Physician:	Ph:		
Living situation:			
Immunizations current? Yes No <i>please bring a copy for our records</i>			
Care provider:			Ph:
Service coordinator:			Ph:

Did mother visit the physician less than 5 times during pregnancy? Yes No
 Did mother begin physician care after 28 weeks (7 months) of pregnancy? Yes No
 Mother's age at time of birth: _____
 Gestational age: _____ Child's birth weight: _____ Length: _____
 Type of delivery: Vaginal Breech Cesarean Was labor induced? Yes No
 Were instruments used? Yes No Did baby stay in NICU? Yes No
 Hospital where baby was born: _____ Birth outside of hospital

Were any of the following conditions present at birth? (circle)

Paralysis	Did not cry	HIV positive	Jaundice
Fractures	Cord around neck	Blue color	Birth defects
Needed oxygen	Breathing problems	Bruised head	Multiple births
Seizures	Other: _____		

Please check any of the following conditions that existed during pregnancy and indicate which month the problem occurred:

Anemia _____	Pesticide exposure _____
Elevated blood pressure _____	X-ray exposure _____
Toxemia _____	Injury _____
Heart problems _____	Chronic kidney disease _____
RH blood sensitization _____	Virus or serious illness _____
Bleeding _____	Problems with placenta _____
Seizures _____	Diabetes _____
Medications _____	Problems with amniotic fluids _____
Drugs/alcohol _____	Smoking (# smoked per day) _____

Does child take a nap? Yes No What time of day? _____ How long? _____

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Does child worry a lot or seem to be afraid?

Describe: _____

Have there been any major changes in the child's life in the past year?

Describe: _____

Does your child enjoy being hugged? Yes No Cuddled? Yes No

Has the client or family participated in any of the following programs? (circle)

Personal Care Services	Well Child Clinic	WIC Nutrition program
Child protection	Head Start	Food stamps
High risk infant care	Indian health services	Financial assistance
High risk maternal care	EPSDT health check	Katie Beckett program
Immunizations clinic	Social security	Family planning
Medicaid	Maternity clinic	Children's special health program

When did you first notice that your child had delays?

What are your primary needs/concerns for your child at this time?

What are your long term goals for your child?

Please list any hospitalizations or operations in your child's medical history and dates they occurred?

Please list any serious accidents or injuries and dates they occurred.

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Does your child have frequent illnesses or infections?

Does your child suffer from any of the following?

Vision problems: (squinting, crossed eyes, getting very close to tv, books, etc.
rapid eye movements) _____

Hearing problems: (chronic ear infections, pain in ear, discharge from ear, tubes
in ears) _____

Has your child ever had a convulsion or seizure? Yes No age: _____

Please list any medications your child is currently taking: _____

—

Last visit to the dentist: _____

Last visit to the physician: _____

Please list any allergies your child may have: _____

—

Approximately how many hours per night does your child sleep? _____

Please list things of special interest or activities that your child especially enjoys:

Are any of the following conditions present in your child's immediate family?

Condition	Who	Comments
Diabetes		
Epilepsy (seizures)		
Birth defects		
Mental health issues		
Learning disabilities		
Vision impairments		
Hearing impairments		
Cerebral palsy		
Speech/language disorder		

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Alcoholism		
Chemical dependency		
Abuse		
Cancer		
ADD/ ADHD		
Mental retardation		
Heart disease		
Autism		

All children learn to do things at different times. Think back to when your child started doing these different things and indicate the age, or check the not applicable box if your child is not doing the activity.

Activity	Age	N/A	Activity	Age	N/A
Respond to loud sounds			Use 2-3 word sentences		
Grasp rattle			Recognize familiar pictures		
Lift head and chest while on tummy			Feed self with spoon		
Smile			Walk up steps alternating feet		
Reach for and pick up objects			Ride a tricycle		
Roll from stomach to back			Put on shoes		
Transfer objects from one hand to other			Use 3-5 word sentences		
Sit without support			Use the toilet		
Pull to standing position			Dress and undress with little help		
Crawl on hands and knees			Wash hands alone		
Drink from a cup			Give first and last names		
Wave bye-bye			Catch a large ball		
Feed self finger food			Bathe self		
Walk without help			Dress alone		
Use 8-10 words that are understood					

Please list any other information that would help us provide the best possible services for your child.

Thank you for taking the time to fill out this information!

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**CHILDREN'S THERAPY PLACE INC.
AUTHORIZATION FOR DISCLOSURE**

Client Information

Client Name _____ Date of Birth _____

Mailing Address _____ State _____ Zip Code _____

Requestor Information to be completed if authorization is being made by someone other than the subject of the information.

Requestor Name Children's Therapy Place Telephone 323-8888

Relationship Therapy Provider

Address 6855 W Fairview Ave Ste 120, Boise State ID Zip 83704

Authorization Details

I authorize the following

To disclose this confidential information to Children's Therapy Place

Address 6855 W Fairview Ave Ste 120, Boise ID 83704

Fax 323-8889 Phone 323-8888

For the purpose of Therapy

Please describe in detail the information to be disclosed

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I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization.

Your signature _____

Date _____

Emergency Contacts

Client Name: _____

Home Address: _____

Parent(s) Name(s): _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Other Ph: _____

Emergency Contact 1: _____ Ph: _____

Emergency Contact 2: _____ Ph: _____

In my absence, you have my permission to leave _____ with the
(Client)
following people: _____

Client will not be left in the care of anyone not listed without written consent.

Emergency Procedure:

In the case of an emergency, or the inability to locate parents when dropping off client, staff will attempt to contact emergency contacts listed. If an appropriate person is unavailable, staff will contact supervisor. No client under the age of 18 will be left unattended without express written permission of parent or guardian.

Authorization to Transport

By signing this form, I authorize a Children's Therapy Place representative to transport my child in a company or personal vehicle, while providing therapy services.

Consent to Treat in a Medical Emergency

By signing this form, I consent for my child to be treated in a medical emergency at the nearest emergency room. If an emergency should occur, any and/or all contacts listed above will attempt to be contacted.

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Client Signature

Date

Legal Guardian/Representative Signature

Date

Agency Representative Signature

Date

Statement of Client Rights

Among the rights guaranteed under IDAPA 16.04.11.760 and Idaho Code Section 66-412 and 66-413 are the following:

1. You will not lose any legal rights because you are a client of Children's Therapy Place.
2. It is assumed you are legally competent beginning with your 18th birthday unless you have been determined otherwise by a court of law.
3. You have the right to exercise all civil rights, unless limited by prior court order, and you have all other rights established by law.
4. You have the right to adequate, courteous and humane services and care in the least restrictive environment; and to receive services which enhance your social image and personal competencies and, whenever possible, promote inclusion in the community.
5. You have the right to privacy, to communicate by telephone or mail, and to receive visitors to all reasonable times and associate freely with persons of your own choice.
6. You have the right to practice your own religion, wear your own clothes, and keep and use your personal possessions.
7. You have the right to refuse to perform services for Children's Therapy Place. If you are hired to perform services, Children's Therapy Place will pay you a wage consistent with state and federal law.
8. You have the right to be informed of your medical and habilitative condition, of services available at Children's Therapy Place, and the charges for the services.
9. Your service plan will be reviewed by you and approved by you. A qualified professional staff member will ensure that the treatment plan is implemented.
10. You have the right to refuse services EXCEPT if such services are to prevent serious harm to yourself or others.
11. You have the right not to be mentally, physically, or verbally abused, corporally punished or neglected.
12. You have the right not to be secluded or mechanically restrained without the convening of a treatment committee as specified in the Children's Therapy Place Policy and Procedures and this can only occur to prevent you from causing physical harm to yourself or others.
13. You have the right to emergency medical services and to be informed of your medical condition.

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14. You have the right to receive a response to any request from Children's Therapy Place, in a reasonable time frame, and the right to voice grievances and recommend changes in policies and/or services being offered.
15. You have the right to review the results of the most recent survey conducted by the department and the accompanying plan of correction.
16. Information in the Children's Therapy Place records is confidential and will not be shared with others without your consent or the consent of the person responsible for you. You will also have reasonable access to your own records.
17. If you believe any of your rights have been violated, the accompanying grievance procedure provides you a method to have your complaint(s) reviewed.

Protection and Advocacy

People with various disabilities are entitled to protection and must have access to advocacy in securing the benefits, services, and rights to which they are entitled. The following are resources, which persons with developmental disabilities may call upon:

Advocacy:

Coalition of Advocates for the Disabled Inc.

Association of Retarded Citizens (ARC)

NAMI

Legal Aid Services, Inc.

Private Attorneys

Family members or friends

Regional Mental Health Authority

Idaho Parents Unlimited (IPUL)

Protection:

Adult Protection Services

Law enforcement agencies

A current and complete list of advocacy and protection services including telephone numbers and addresses can be obtained from Children's Therapy Place.

By my signature below, I affirm that I have read or have had explained to me all my rights as a client of Children's Therapy Place. My signature also confirms that I have had a chance to review and discuss each right listed above with an employee of Children's Therapy Place and that I have received a copy of the 'Statement of Client Rights'.

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Confidentiality Acknowledgement

Medicaid/ Insurance Policy: I request that payment of authorized Medicaid/insurance benefits be made to Children's Therapy Place on my behalf.

Health Insurance Privacy Accountability Act (HIPAA): Children's Therapy Place clients acknowledge that by signing this document, Children's Therapy Place may use identifying information about clients for the purpose of treatment, payment, and operation. Clients have the right to review all privacy notices before signing, have the right to requests and restrictions on disclosure, and have the right to revoke consent. Further information regarding HIPAA can be located under 164.520 of the IDAPA code.

Confidentiality Policy: Children's Therapy Place clients acknowledge that by signing this document, all client information written/verbal and client interactions will be confidential. Information will only be exchanged with other Children's Therapy Place employees or individuals with signed releases of information who are actively involved in treatment/services.

Exceptions to Confidentiality: There are exceptions to complete confidentiality with which Children's Therapy Place must comply. Some of these exceptions include child abuse, suicidal clients, Tarasoff 'duty to warn', joint custody decrees, Guardian Ad Litem, Crime Victim Compensation Program, and subpoenas. Children's Therapy Place is required to report to the appropriate authorities when any of these circumstances are disclosed or present themselves.

Appointment Policy: All scheduled appointments must be kept or cancelled 24 hours in advance. If there are 3 missed appointments (no call prior to the scheduled appointment or no show) during the course of service, a client's services will be subject to discontinuation. A 30-day notice of possible discontinuation will be sent.

Payment is expected at the time of service, when applicable.

By my signature below, I affirm that I have read or have had explained to me the 'Confidentiality Acknowledgement' of Children's Therapy Place. My signature also confirms that I have had a chance to review and discuss the 'Confidentiality

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Grievance Acknowledgement

All Children's Therapy Place clients and/or their representative will have the right to file grievances in regard to services rendered, environmental amenities and personnel and peer issues. All Children's Therapy Place personnel will be advised that all grievances must follow the procedure as described. If a staff member of Children's Therapy Place refuses to assist a client they will be immediately terminated. Should a client or their representative choose to use this procedure, it will in no way adversely affect their care of treatment at Children's Therapy Place.

When a client or their representative files a grievance, they will be encouraged to involve a spokesman at all stages of the process. Steps for the process will be as follows:

1. The grievance will be reviewed directly with a Children's Therapy Place employee within 5 business days of the action being grieved.
2. The grievance will be reviewed and documented by the Children's Therapy Place and brought to the attention of the supervisor for resolution.
3. If the grievance cannot be settled the issue will be brought to the next higher level of supervision for resolution, and continue until it has reached the Owner/Administrator.
4. At each level of supervision a resolution should be reached or taken to the next level within 48 hours. The time frame for a resolution should not exceed 10 business days or it should reach the Owner/Administrator.
5. An impartial arbitrator will be called upon to resolve the grievance if a resolution is not met between the client and the Owner/Administrator. A meeting will be scheduled with the client and/or their representative, the Owner/Administrator, and the program director within 5 business days.

Once concluded, the grievance forms will be filed with the program director and in the administrative files.

By my signature below, I affirm that I have read or have had explained to me the 'Grievance Acknowledgement' of Children's Therapy Place. My signature also confirms that I have had a chance to review and discuss the 'Grievance Acknowledgement' with an employee of Children's Therapy Place and that I have received a copy of the 'Grievance Acknowledgement'.

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