The Lotus Tree
Sensory Integration Center
3169 South Bown Way
Boise, Idaho 83706
p) 208-433-9152
f) 208-344-4752
www.lotustreeboise.com

Patient Information (0-24 months) Today's Date: ____/____/____

Patient's Full Name _____ Date of Birth ____/____/____ F☐ M☐

Parent/Guardian 1 _____ Cell _____ Work _____

Parent/Guardian 2 _____ Cell _____ Work _____

Street address _____ Home phone _____

City _____ State _____ Zip _____ Email _____

Patient's Physician _____ Phone _____

Diagnosis/es with dates _____

Referred by _____ Service Coordinator (if applicable) _____

What therapies has patient received within the current calendar year: _____

_____

Insurance (Please also present your insurance card to our staff for copying

Primary Insurance Provider _____ Medicaid # _____

Subscriber # _____ Group # _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Date of Birth ____/____/____ Place of Employment _____

*Subscriber Address _____ City _____ State ____ Zip_____

**(If different than patient's address)*

Family Information

Primary language in home: _____ Other language spoken in home: _____

Baby lives with: ☐ Both birth parents ☐ Mother ☐ Father ☐ Foster parents/guardian

☐ Adoptive parents ☐ Parent and stepparent ☐ Other: _____

Other children in family:

Name	Age	M/F	Grade	Developmental Concerns
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Birth History

Place of Birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ _____

Delivery: ☐ Vaginal birth ☐ Cesarean Section ☐ Breach ☐ Forceps ☐ Vacuum assist

Pregnancy or delivery complications? ☐ Yes ☐ No

If yes, please explain: _____

_____

Baby's birth weight: _____

Did baby have any of the following?

☐ Premature birth: How many weeks was pregnancy? _____

☐ NICU stay: How long? _____

☐ Jaundice: Treatment _____

Feeding

☐ Breastfeeding How often? _____ How long? _____

☐ Pain w/Breastfeeding (*Rate Pain on Scale of 1 – 10)* ☐ Right _____ ☐ Left _____

☐ Bottle feeding How often? _____ Volume? _____

Which bottle? _____

How long does it take to finish a bottle? _____

Breast milk _____ or Formula _____

☐ Pumping How often? _____ How long? _____ Amount? _____

☐ Frenectomy Lip tie _____ Tongue tie _____ Date of procedure: _____

Performed by: _____

Supplements for Milk Supply _____

Have you received outpatient lactation support? ☐ No ☐ Yes From: _____

Current Health

Baby's current weight: _____

Current medications: _____

Alternative, homeopathic, herbal therapies being used: _____

Allergies or sensitivities to medications or foods: _____

What are your concerns about your baby? _____

Does your baby turn their head more to one side than the other? ☐ No ☐ Yes: Which side _____

Does your baby have any flatness or asymmetries on their head that you have noticed? ☐ No ☐ Yes: Where_____

_____

The Lotus Tree Sensory Integration Center Policies and Procedures

Please initial each line and sign below. Thank you.

____ I request and consent to receive treatment for _____at The Lotus Tree Sensory Integration Center

____ Information provided on the Patient Information form is correct to the best of my knowledge. I grant The Lotus Tree Sensory Integration Center the right to release my medical information and treatment history to third party payers and/or other healthcare professionals as needed.

____ I and/or the responsible party agree to assign The Lotus Tree Sensory Integration Center and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

____ I understand that if my insurance provider requires a referral for treatment, it is my responsibility to obtain the referral prior to my first appointment. I also understand that if I do not have prior written authorization I am fully financially responsible for any unpaid balances of current or past appointments. I accept responsibility for keeping my referral/authorization current and renewing it when necessary. Further, I agree that I am responsible for payment for any visits beyond that of my insurance coverage.

____ I authorize The Lotus Tree to submit claims on my behalf to my health insurer. I authorize my insurance company to make payments directly to The Lotus Tree for services rendered.

____ I understand that my bill is to be paid within 30 days of the invoice date unless otherwise arranged with The Lotus Tree billing department. I understand that after 30 days a late fee of 1.5% monthly will be added to my account. I understand that there is a $35.00 fee for each check returned unpaid. In the event of default of payment I agree to pay fees accrued on my balance due, as well as collection costs and/or legal fees incurred for collection of my account.

____ The Lotus Tree requires 24 hours notice in the event of a cancellation. The Lotus Tree recognizes that in an unforeseen circumstance an absence without notification may occur. However if a second absence should occur, a $25.00 fee will be charged to your account. A third absence of appointment will result in possible termination of services at The Lotus Tree.

Release of Liability

____ I am fully aware of the risk of injury and/or death, as well as other damages and losses associated with the participation in activities at The Lotus Tree. I hereby waive and release the owner, staff members, and/or therapists employed by The Lotus Tree of liability for personal injury or accident of any sort suffered by the participant named above while participating in classes, treatment or any other sponsored activities at The Lotus Tree.

____ I understand the nature of these activities and understand the minor's capabilities, health level and physical condition, and believe the minor to be qualified to participate and/or receive treatment at The Lotus Tree Sensory Integration Center.

____ In the event myself or my child requires emergency care, I hereby authorize an associate of The Lotus Tree Sensory Integration Center to obtain medical care and treatment without further authorization.

Name (Please Print) _____ Signature _____ Date _____

Patient's name (Please Print) _____ Relationship to Patient_____

In the event of an emergency, please contact: _____ Phone: _____

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

PLEASE CHECK ONE

☐ I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information.

☐ I waive my right to read your *Notice of Privacy Practices.*

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* Furthermore, I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient (If patient not signing): _____

Signature: _____ Date: _____