The Lotus Tree

Patient Information (Child) Today's date: ____/____/____

Patient's Full Name (please print) _____ Date of Birth ____/____/____ F ___ M ___

Parent/Guardian 1 _____ Cell _____ Work _____

Parent/Guardian 2 _____ Cell _____ Work _____

Street address _____ Home phone _____

City _____ State _____ Zip _____ Email _____

Primary Care Physician _____Phone _____

Diagnosis(es) with dates _____

Do you agree with diagnosis(es)? _____

Referred by _____

What therapies has patient received within the last calendar year? Please include therapist's name, location and, for repeating appointments, days and times: (OT, PT, SLP, Music therapy, Aquatherapy, Counseling, etc)

_____

_____

Insurance (Please also present your member card to our staff for copying. Thank you.)

Primary Insurance Provider _____

Subscriber # _____ Group # _____

Subscriber Name & Relation to patient _____ Date of Birth ____/____/____

Secondary Insurance Provider _____

Subscriber # _____ Group # _____

Subscriber Name & Relation to patient _____ Date of Birth ____/____/____

Subscriber's Address * _____ City _____State ____ Zip_____

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

Please check with your insurance carrier to learn your plan's benefits, deductible and pre-authorization requirements for Outpatient Therapy Services.

School Information (if applicable)

Name of school: _____Teacher's name: _____

Grade: _____ Has child ever repeated a grade? ___ yes ___no

Strengths and/or best subjects: _____

Difficulty with any subjects: _____ Receiving help with any subjects: Y N

Comments/concerns about school: _____

_____

Family Information

Primary language in home: _____ Primary language of child: _____

Other language spoken in home: _____Child speak language? Yes ___ No ___

Any cultural influences in the home or family _____

Child lives with: ___Both birth parents ___Foster parents ___Mother OR ___Father

___ Adoptive parents ___Parent and Step-parent ___Other: _____

Other children in family:

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

Birth History

Explain anything unusual about the pregnancy or birth? _____

Mother's age at birth: _____ years old Child's birth weight: _____

Did patient have the following?

___premature birth, how many weeks was pregnancy? _____

___NICU stay, how long? _____

___colic

___poor suck, swallow, breathing

___infant sensitivities, explain

_____

Developmental History

Please note the approximate age your child achieved the following developmental milestones:

rolled _____ crawled _____ babbled _____ put two words together _____

sat up alone _____ walked_____ said first words _____ toilet trained _____

Current Health

Current Medications: _____

_____

Alternative, homeopathic therapies child receives: _____

_____

Describe your child' s health concerns: _____

_____

Describe behavioral concerns: _____

_____

Describe your child's strengths: _____

_____

What areas do you hope your child will improve during therapy? _____

_____

Are there any nutritional or feeding problems? _____

_____

Describe any sensitivities (noise, taste, etc.): _____

_____

Allergies to medications or foods: _____

_____

Check all that apply:

- ☐ Constipation
- ☐ Hernia
- ☐ RSV
- ☐ Cancer
- ☐ Hearing loss
- ☐ Motor skill issues
- ☐ Head injury
- ☐ Irritable bowels
- ☐ Diarrhea
- ☐ Asthma
- ☐ Surgeries
- ☐ Diabetes
- ☐ Reflux
- ☐ Seizures
- ☐ Allergies
- ☐ Other
- ☐ Oral/speech problems
- ☐ Drug/alcohol exposure
- ☐ Heart problems
- ☐ Depression/anxiety
- ☐ Missed milestones
- ☐ Ear infections/tubes
- ☐ Thumb/finger sucking
- ☐ Swallowing restrictions
- ☐ Feeding difficulties
- ☐ Stomach problems
- ☐ Skin problems
- ☐ Hearing loss
- ☐ Sleeping difficulties
- ☐ Vision problems

Please give more details about all areas checked *(use back side of page if needed)* _____

_____

The Lotus Tree Sensory Integration Center Policies and Procedures

Please initial each item and sign below indicating your understanding and acceptance. Thank you.

____ I request and consent to receive treatment for _____ at The Lotus Tree Sensory Integration Center. *(Hereinafter "The Lotus Tree")*

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

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

____ 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 referral from my physician, I am fully financially responsible for any unpaid balances of current or past appointments. Further, I agree that I am responsible for payment for any visits beyond that of my insurance coverage.

____ I understand that my bill is to be paid within 30 days of the invoice date unless I have made other arrangements with The Lotus Tree billing department. 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/my child's account.

____ The Lotus Tree requires a 24 hours' notice in the event of a cancellation. The Lotus Tree recognizes that in an unforeseen circumstance an absence without notification can occur. However if a second absence should occur, a $15.00 fee may be charged to your account. A third absence may result in termination of services.

Release of Liability

____ I am aware of the risk of injury and damages, known or unknown, associated with the participation in activities at The Lotus Tree. I hereby waive and release the owner, staff members, therapists and others employed by The Lotus Tree of liability for personal injury or accident suffered by the participant named, by reason of participation in classes, treatment or other activities at The Lotus Tree. I hereby agree to release The Lotus Tree of any liability for litigation expenses, attorney fees or loss liability that may occur as the result of any such claim.

____ I understand the nature of the treatment and activities and I 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.

____ In the event my child or I require emergency care, I hereby authorize any associate of The Lotus Tree 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: _____

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: _____