



3607 Manchaca Rd., Austin, TX 78704 • 512-444-7219 Phone • 512-444-6005 Fax

### WELCOME TO KIDWORKS!!!

We would like to take this opportunity to welcome you to **KidWorks (KW)** and to thank you for choosing our services for your child and your family. We are dedicated to providing quality Occupational, Speech and Language, and Physical Therapy services using a family-centered approach! Your entire family will benefit from the services, support and education that will be offered. This approach will assist not only your child, but also your family in understanding and overcoming the various challenges that your child faces.

**KidWorks is** committed to the wonderful and vast fields of Occupational, Speech and Language, and Physical therapy. We encompass a wide range of therapeutic methods and interventions that your whole family will learn to understand, enjoy and benefit from. **KidWorks** emphasizes a professional environment of diverse experience, on-going continuing education and a progressive approach to new concepts in this ever growing and changing field. This is crucial in providing you with the most current information and treatment possible.

**KidWorks** takes great pride in giving your child and your family undivided attention and time. It is very important to work in a nurturing environment that meets the individual needs of your child. In addition, education and support are provided to your entire family because the difficulties and challenges that your child faces affect everyone involved. Our therapy process focuses on emotional and social development within a relationship based model utilizing DIR/Floortime principles. You and your child deserve nothing less.

Welcome to the **KidWorks** team! A marvelous journey of exploration, challenge, fear, excitement and hope lies ahead. Together, we will face this journey to help your child grow, improve and gain successful experiences that will enhance their life and your family's as well.

Please contact us directly with any concerns.

### **The Management Team at KidWorks Therapy:**

**Rebecca Pokluda, Clinic Director**

**Liz Darwin, Assistant Clinical Director**

**Jeanette Hutchinson, Office Operations Manager**

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CREATING SOLUTIONS..... CREATING SUCCESS

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# General Guidelines

The following information is a list of general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your therapist.

1. Please have your child dressed in clothing that is easy to move in and is OK if it gets dirty.
2. If you want to observe the treatment session, please discuss this with your therapist first. Due to the HIPAA privacy laws there is a specific procedure that must be followed to ensure the privacy of other clients in the gym.
3. Parents are required to be present in treatment for the last 10 minutes. The last 10 minutes of the treatment session may be used for family education, discussion and documentation. If you feel that you need additional time to discuss issues, please schedule that time with your therapist. This will prevent running into the next appointment. If you leave the clinic during your child's therapy time, please return to 10 minutes prior to the end of the session to allow ample time for therapist to discuss the session and complete documentation.
4. You will be notified as far in advance as possible when your therapist is ill, on vacation or attending a conference. Every effort will be made to reschedule your appointments so that your child will miss as little treatment as possible.
5. A client may be sent home because of a health need if he/she:
  - Appears ill and is unable to participate in therapy.
  - Is suspected of having a contagious disease/condition.
  - Sustains an injury which needs medical attention or close observation.
  - Has active head lice.
  - Exhibits vomiting and diarrhea during school hours.
  - Has a fever of 100.4 or greater (a client may not return to KidWorks until fever free for 24 hours off of fever reducing medication such as Tylenol or Motrin).  
\*If the client is restricted or limited in any way due to illness or accident, a note from the doctor at the time of the client's return to therapy may be required.
7. Please leave information on how to contact you if you do not stay for the treatment hour in case of any emergencies. Also, please be prompt in picking up your child before their session is over. We do not have the means for childcare. Failure to return in a timely manner more than one time will result in a requirement that you do not leave the premises during your child's treatment.
8. Cancellation Policy: Please provide 24 hour notice to cancel an appointment. A charge will be incurred if less than 3 hour notification is provided to cancel an appointment. Voicemail may be used to cancel an appointment through the office.
9. It is essential to maximize therapeutic gains of intervention that you consistently attend your regularly schedule appointments. Missing more than 50% of your scheduled sessions within a 4 week period or if you have 3 "no show" cancellations within one year will result in the loss of a reserved treatment time slot. We highly encourage rescheduling appointments when you need to cancel.
10. It essential for the success of your child's treatment that you attend your scheduled sessions. There is also a high demand for treatment at our practice. For these reasons if more than 3 consecutive weeks of treatment are missed, your reserved appointment time will be forfeited if another client is waiting for that spot. Your child will be placed on the waiting list for another time slot. Thank you for your consideration in this situation.
- 11 E-mail Policy: Email may be used to cancel an appointment 24 hours prior to an appointment or to request a schedule change. We ask for you to communicate all schedule changes with your therapist. [kidworkscommunity@gmail.com](mailto:kidworkscommunity@gmail.com)  
**(Please Note)** *This email is only used for cancellations or scheduling changes. If you have something that you need to discuss with your therapist please speak to them in person at the time of your child's appointment.*

**DEMOGRAPHIC INFORMATION**  
**INFANT FORM (BIRTH TO 12 MONTHS)**

**Child's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Mother/Guardian's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Father/Guardian's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Living Situation: (circle one)    Married        Single        Divorced/Separated        Other

Email Address: \_\_\_\_\_

Would you like for us to email you information regarding upcoming programs, etc.?    Yes                      No

**INSURANCE INFORMATION:**

Primary Insurance Co. \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

Insured: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group No. \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

Insured: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group No. \_\_\_\_\_

**I hereby give KidWorks Therapy Services authorization to file claims for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility.**

\_\_\_\_\_  
**Responsible Party Signature**

\_\_\_\_\_  
**Date**

**BIOLOGICAL INFORMATION**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Person completing this form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Siblings: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

What language(s) are spoken in the home? What is the primary language spoken?  
\_\_\_\_\_

Current concerns/reason for referral: \_\_\_\_\_  
\_\_\_\_\_

When was the concern, first noticed? By whom? \_\_\_\_\_  
\_\_\_\_\_

Has the concern/ problem changed since it was first noticed?  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION:**

Please circle all that apply and/or fill in the blanks.

Physician: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Phone: \_\_\_\_\_

Does your child see other specialist(s)?  
Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Other Professional Providers: (occupational, physical or speech therapy) etc): *please list names of therapists*  
\_\_\_\_\_  
\_\_\_\_\_

Do other family members have any speech, motor, cognitive, or other disorders/delays? If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## DEVELOPMENTAL MEDICAL HISTORY

The following questions are posed to help in compiling a more complete picture of your baby. Please answer the following questions as best you can. If there is not adequate space for your comments, please continue to write on the back of this form. Thank you very much for taking the time to complete this history. It will help us greatly!

### MOTHER'S PREGNANCY AND CHILD'S BIRTH:

Please circle Yes or No to the following questions and remark in the space provided.

1. Were there any infections/illnesses during pregnancy? Yes No \_\_\_\_\_

2. Were there any drugs or medications taken during pregnancy? Yes No \_\_\_\_\_

3. Was there any unusual stress during pregnancy? Yes No \_\_\_\_\_

4. Was the pregnancy full-term? Yes No Premature delivery? Yes No \_\_\_\_\_

5. Was the labor normal? Yes No (Specify) Yes No \_\_\_\_\_

6. Was the delivery normal? Yes No (Specify) Yes No \_\_\_\_\_  
(Cesarean section, breech, sideways, cord around neck, forceps used)

7. Was medication given during delivery? Yes No \_\_\_\_\_

8. Were there any other complications during the pregnancy? Yes No \_\_\_\_\_

9. What was the child's weight at birth? \_\_\_\_\_

10. Were there any complications? Seizures jaundice congenital defects other: \_\_\_\_\_

11. Was there a need for: oxygen transfusions tube feedings other: \_\_\_\_\_

12. Did your infant cry right away? \_\_\_\_\_

13. Did your infant have a hearing test? What were the results? \_\_\_\_\_

13. What was the length of the infant's hospital stay? \_\_\_\_\_

14. Is your infant currently breast fed, bottle fed, tube fed or a combination?  
\_\_\_\_\_

15. Are you concerned about your infant's feeding?  
\_\_\_\_\_

16. Please state any other difficulties or special cares: \_\_\_\_\_

Please feel free to attach any hospital discharge or prior therapy information that is important to the care of your infant.

Current health: \_\_\_\_\_ Current weight: \_\_\_\_\_ Current length: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Results: \_\_\_\_\_

My child currently sleeps/naps:      inconsistently      well      restless      other

My child currently eats/drinks:      at regular/irregular intervals      consistent/inconsistent amounts

Describe your child's current demeanor/behavior: \_\_\_\_\_

\_\_\_\_\_

Current Medications/Dosage/Frequency: \_\_\_\_\_

\_\_\_\_\_

Known Allergies (milk, latex, etc):

\_\_\_\_\_

### **SOCIAL/ EDUCATION HISTORY:**

Who does your infant stay with during the day? \_\_\_\_\_

Activities your child  
enjoys: \_\_\_\_\_

\_\_\_\_\_

### **DEVELOPMENTAL MILESTONES:**

Please list the age that your child did the following and answer questions below (in months).

Roll \_\_\_\_\_ Sit \_\_\_\_\_ Belly crawl \_\_\_\_\_ Crawl on hands/knees \_\_\_\_\_ Walk \_\_\_\_\_

Run \_\_\_\_\_ Skip \_\_\_\_\_ Vocalize \_\_\_\_\_ Finger feed \_\_\_\_\_ Use spoon \_\_\_\_\_

Drink from cup with assistance \_\_\_\_\_

How do you know when your baby is hungry?: \_\_\_\_\_

How do you know when your baby is sleepy?: \_\_\_\_\_

How do you know when your baby needs a new diaper? \_\_\_\_\_

1. Do you feel that your baby met his/her early milestones on time when compared to peers or siblings?

\_\_\_\_\_

2. Do you have concerns or questions about his/her development? \_\_\_\_\_

\_\_\_\_\_

3. Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, distracted by sounds, etc.):

\_\_\_\_\_

3. Do you have difficulty getting your infant to calm? \_\_\_\_\_

4. Are you able to bathe your infant easily? \_\_\_\_\_

Are there any cultural or religious beliefs that you would like us to be aware of and/or take into consideration when we are working with your child? \_\_\_\_\_

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**PLEASE USE SPACE BELOW FOR FURTHER COMMENTS:**



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## PHOTOGRAPH AND VIDEO RELEASE FORM

I authorize KidWorks Therapy Services to photograph my child for use in the following categories. Parents or other clients may ask the names of the children in the pictures. I authorize that my child's first name may be mentioned when referring to these pictures.

This authorization is valid from the date signed below. I understand that I may revoke this authorization at any time, but will not hold KidWorks Therapy Services responsible for pictures already taken of my child.

Please check "Yes" or "No" to indicate your preferences.

<b><u>I Give KidWorks Permission to:</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>
Take photographs or video for educational purposes	_____	_____
Use photos within the clinic	_____	_____
Use photos on company website	_____	_____
Use photos in flyers, brochures, or publicity ads	_____	_____
Email to parent of videos taken for educational purposes	_____	_____

*\*\*I understand that email may not be HIPAA compliant and that KidWorks will not use email for any other correspondence.*

Name of Child: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_





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## CONSENT AND ACKNOWLEDGEMENT

**Consent for Care and Treatment:** As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as is necessary in her judgment. I understand that my child is under the care and supervision of my therapist. I authorize release of medical information to the KidWorks team for continuity of care. KidWorks Therapy Services is a teaching facility. There will be students, volunteers, and clinical interns that may be observing or supporting the therapists in treatment areas. I authorize this as a part of my child's treatment at KidWorks Therapy Services.

\_\_\_\_\_  
Signature of legal representative of child

\_\_\_\_\_  
Date

**Acknowledgement of Notice of Privacy Practices:** I acknowledge that KidWorks will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. Our Notice of Privacy Practices provides further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

\_\_\_\_\_  
Signature of legal representative of child

\_\_\_\_\_  
Date

**Consent for Parent Observation:** I understand that other parents may observe my child in therapy as the parents observe their child in therapy.

- I consent to the presence of other parents in the same treatment area with my child as the parents observe their child in therapy.
- I do not consent to have other parents in the same treatment area as my child.

\_\_\_\_\_  
Signature of legal representative of child

\_\_\_\_\_  
Date

**Consent for Email:** I understand that e-mail is not HIPPA compliant or a confidential method of communication. I further understand that there is a risk that e-mail communication between KidWorks and myself may be intercepted by third parties or unintended parties. Email correspondence is solely to be used for brief and logistical matters: scheduling, insurance benefits, and monthly statements. It should not be used for anything related to therapeutic interventions.

- I consent for KidWorks to email me regarding my insurance benefits, scheduling and my monthly statement.
- I do not consent to receive emails from KidWorks regarding my insurance benefits, scheduling and my monthly statement.

Email Address \_\_\_\_\_ Name of child:

\_\_\_\_\_  
Signature of legal representative of child

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



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## PROCEDURE FOR OBSERVING YOUR CHILD IN THERAPY

To ensure compliance with HIPAA, parents are not allowed in the treatment area unless specific arrangements have been made with your therapist.

To maintain the confidentiality of clients during their therapy session, the following procedures must be observed:

1. Parents choosing to observe must sign a statement of confidentiality.
2. While observing your child's therapy, you may be asked to leave the treatment area or the location of your child's therapy. The location may have to be modified if one of the clients in the gym/treatment area requests that no other parents be in the same room as their child during treatment.
3. Siblings are not allowed in the treatment area unless authorized by the treating therapist for therapeutic reasons.
4. Cell phone use is not allowed in the treatment area.
5. Stay only in the area in which your child is working.
6. Please respect the other client's therapy sessions in the event your presence is distracting. **You may be asked to leave the treatment area if your presence is affecting your child or other client's treatment. In the instance when there is more than one person observing, we may ask that only one person be in the treatment area to protect the quality of treatment.**

### Statement of Confidentiality

The undersigned hereby acknowledges his/her responsibility under federal applicable law and the Agreement to keep confidential any information regarding KidWorks' patients, as well as all confidential information of KidWorks. The undersigned agrees under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient, and further agrees not to reveal to any third party any confidential information of KidWorks, including policies and procedures.

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
DATE

**Authorization for Release and Disclosure of Protected Health Information**  
**In accordance with state and regulatory agency requirements, the medical record is the property of KidWorks.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

I hereby authorize that my medical information be released:

TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FROM:

**KIDWORKS THERAPY SERVICES**  
**3607 Manchaca Road**  
**Austin, TX 78704**  
**512-444-7219**

Please release the following information:

- Initial Evaluation       Re-evaluation       Progress Notes       Plan of Care  
 History and Physical       Discharge Summary       Psychological Evaluation  
 Other (Specify) \_\_\_\_\_

This information is necessary for the following purpose:

Continued Patient Care     Insurance     Personal Use     Other (specify) \_\_\_\_\_

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the administrative office of KidWorks Therapy Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. Unless otherwise revoked, this authorization will not expire.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the office manager at (512) 444-7219.

\_\_\_\_\_  
Signature of Patient or Legal Representative      Date

\_\_\_\_\_  
Relationship to Patient

This information has been disclosed to you from records protected by federal law (42 USCA Sec. 290-dd (2)). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 USCA Sec. 290-dd(2).

# NOTICE OF FINANCIAL RESPONSIBILITY

## KidWorks Therapy Services

- KidWorks Therapy Services appreciates the confidence you have shown in choosing us to provide for your child's therapy needs. The services that you have elected to participate in, implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of the services provided.
- You are responsible for the payment of any payment and co-payment amount due at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier.
  - You may place a credit card on file with a release to bill your credit card on the 1<sup>st</sup> Friday of every month for your copayment/Coinsurance payments. If you elect to not place a credit card on file for copayment/coinsurance and your portion of the payment is not received before the end of your appointment a \$10 late fee will be applied.
  - Please understand that many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you elect to continue therapy past your approved period, you will be responsible for your account balance in full. Failure to do so will result in your child being placed on hold until balance is paid in full or a payment plan has been created with the office management.
- Certain plans require authorization prior to beginning treatment. It is your responsibility to track the number of visits that your child is seen. If you exceed the number of authorized visits, you will be charged the regular rate for non-covered services. Please take into account any services you may have received at a different facility within the contract year with your insurance company.
- If payment due is not made within 90 days of the date of the first invoice the account will be turned over to Collections for management and collection of that account. Additional fees will be added.
- I authorize the release of any medical information necessary to process the insurance claim. I further authorize payment of medical benefits to Rebecca Pokluda, P.C. dba KidWorks Therapy Services.
- All Returned Checks will incur a \$30 service fee and you will no longer be able to use checks as a form of payment.
- If KidWorks is unable to process your monthly credit card run a \$10.00 service fee will incur. Payment must be made within 30 days to avoid a \$10.00 daily fee, which will incur until your balance is paid in full.
- KidWorks will provide an initial copy of your child's evaluations and billing statements. If any additional copies are requested a fee will incur.
- Parent conferences and Ard meetings are a non-covered insurance service that are offered under our fee for service rate of \$95.00/Hr.
- All visits off site of clinic including school visits, home visits, or day care visits will incur a \$10 service fee per service.
- Consultations including phone, text, and email over and above regular speech-language, occupational or physical therapy will incur a minimum of a \$23.75 fee. Consultations will be billed in 15 minute increments and will be the responsibility of the parent/guardian. Insurance will not cover additional consultation over and above the regular treatment sessions.
- It is your responsibility to inform the office if there is an insurance change and provide the office with the new insurance card. Any treatment provided without the current insurance information on file prior to your child's appointment will be the client's responsibility.
- All questions regarding billing, insurance claims, or payments should only be directed to our billing specialist Crystal Castillo. Therapists do not have information regarding billing or charges, in order that their entire focus is on your child and family. Crystal Castillo will be happy to assist you and can be reached at: **512-444-7219 or 956-792-6794 between the hours of 8:00 am-5:30PM.**
- Please inform the office of any foreseen cancellations within 24 hours of your appointment time. All No-Show or Short Notice (less than 3 hour notice) appointments will incur a \$40.00 fee. Please note that insurance companies do not reimburse for these charges and they will be your responsibility. All fees will be strictly enforced during holidays when appointments have been confirmed and therapists' agree to see your child. Two "no show" cancellations, missing more than 50% of the scheduled treatment sessions, or habitual cancellations will result in the loss of a reserved treatment time slot.

### FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she is the responsible party and accepts these terms. I certify that any and all information given by me to KWTS 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. The undersigned certifies that he/she is the responsible party and accepts these terms.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Child's Name



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## Authorization to Use Credit Card on File

Patient Name: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Credit Card#: \_\_\_\_\_

Visa       Mastercard       Discover      **Exp. Date:** \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize KidWorks Therapy Services to use the credit card provided to them to pay the deductible, copayments, allowable amounts and any unpaid services from Insurance. All cards will be run once a month to pay balance in full. If KidWorks Therapy is unable to process my payment a \$10.00 service fee will incur. Payment must be received within 30 days to avoid a \$10.00 daily fee, which will incur until the balance is paid in full.

KidWorks Therapy Services will keep the credit card information confidential. I understand it is my responsibility to notify the office if I choose to cancel this agreement.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinic Manager

\_\_\_\_\_  
Date