30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688 Ph: 949-459-1658 Fax: 949-459-1667 www.rainbowkidsachievementcenter.com

# General Guidelines

Child's name: _____ DOB: _____

The following information is a list of general guidelines that will assist in creating an intervention and treatment environment that is efficient and effective as possible.

Please initial all guidelines as well as sign the bottom.

1. _____ Please arrive on time for all appointments.
2. _____ Please have your child dressed in comfortable clothing that may get dirty.
3. _____ If your child will be attending feeding therapy, please provide appropriate food requested by your therapist.
4. _____ If your child is attending multiple sessions or staying multiple hours for a program, please pack a snack and diaper changing supplies.
5. _____ We encourage all of our parents to participate in their child's program. Due to HIPAA privacy and laws, it is important that you remain with your treating therapist or teacher throughout the portion of your session or remain in the front waiting area.
6. _____ If you are running late for a session or program, please call the front office and let us know.
7. _____ If you choose to leave the premises during your child's program or therapy, please be prompt in picking up him/her when their session or program is over. Please return 10 minutes before the scheduled end of session. If you are late picking up your child, there is a $1.00 fee for every minute late, to be paid immediately.

_____ _____

Parent Signature Date

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# Admissions Checklist

Child's name: _____

- Service Agreement
- Attendance Policy/Cancellation Policy
- Authorization to Release and Request Information
- Consent to Participate/Release of Liability
- Confidentiality Statement/ Grievance Procedures
- Consent to Photography, Videotape, and Audiotape/Medical Treatment
- Consent for Parent Observation and Bathroom Release
- Parent Participatory Program/Site Waiver
- Client Notice of Financial Responsibility
- Patient Information
- Emergency plan

Rainbow Kids
ACHIEVEMENT CENTER

30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688 Ph: 949-459-1658 Fax: 949-459-1667

# Service Agreement

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes
complex, it is very important that you read them carefully and that you ask any questions you have about the procedures. When you sign this document, it will also represent an agreement between you and Rainbow Kids Achievement. You may revoke this agreement in writing at any time. That revocation will be binding with Rainbow Kids Achievement Center unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions or concerns, please feel free to discuss them with us.

*SERVICES OFFERED*

Rainbow Kids Achievement Center will provide services specifically designed to help you and/or your minor child, or otherwise provide you with referrals to other professionals. Rainbow Kids Achievement Center Behavioral Services consist primarily of individual behavioral and skill assessments and short and long-term applied behavioral analysis services to the pediatric population. Rainbow Kids Achievement Center therapeutic services consist of occupational therapy, physical therapy, and speech and language therapy. Rainbow Kids Achievement Center educational and Early Intervention services consist of early education to client and families.

*PROFESSIONAL RECORDS*

Rainbow Kids Achievement Center, pursuant to HIPAA, keeps clients' Protected Health Information in two sets of professional records. One set contains hard copies of clinical records and professional notes, another is an Electronic Medical Chart; a password protected web-based data collection system called WebPT. All clinical records include information about reasons for seeking professional services, the impact of any current or ongoing

problems or concerns, assessment, consultative, or therapeutic goals, progress towards those goals, a medical, developmental, educational, and social history; treatment history; any treatment records that we receive from other providers, reports of any professional consultations; billing records, releases, and any reports that have been sent to anyone, including statements for your insurance carrier. These records are available to you at any time, upon request.

*HIPAA Privacy Practices*

Rainbow Kids is required by law to maintain the privacy of your protected health information. We follow HIPAA policies and regulations. We at Rainbow Kids understand that information about you and your health is personal; therefore, we are committed to protecting health information about you.
We create a record of the care and services that you receive at Rainbow Kids. We use this record to provide you with quality care as well as to comply with legal and other requirements. This record is the property of Rainbow Kids, but the information in the record belongs to you.

This notice applies to records of your care, called Protected Health Information, generated by or at Rainbow Kids Achievement Center, whether made by RKAC personnel or your personal doctor. It includes information that can be used to identify you and that we have created or received about your past, present, or future health or condition, treatment, and payment for healthcare services. This notice explains how, when, and why we use and disclose your protected health information.

How We May Use and Disclose Your Protected Health Information
The following categories will describe different ways that we will use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways in which we are permitted to use and disclose information will fall within one of these categories.

1. For treatment**:** We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services
2. To obtain payment for treatment: We may use and disclose your protected health information to bill and collect payment for the treatment and services provided to you
3. For public health activities: We may use and disclose protected health information for public health activities
4. For health risks: We may disclose protected health information about you for public health risk reporting. For example, we will report information to report the abuse or neglect of children, elders, and adults
5. Health oversight activities**:** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws
6. Appointment reminders and health related benefits: We may use protected health information to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer

7. Law enforcement: We may release protected health information in response to a court order, subpoena, warrant, summons, administrative request, investigative demand, or similar process
8. Required by law: We may release protected health information if we are required by law to do so

*Client Rights*

HIPPA provides you with several rights with regards to your Clinical Records and disclosures of protected health information. These rights include requesting that we amend you record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded, and the right to a paper copy of this Agreement. We are happy to discuss any of these rights with you.

*CONSENT*

Your signature below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above.

_____

Client's Name

_____ _____

Parent Signature Date

30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688 Ph: 949-459-1658 Fax: 949-459-1667www.rainbowkidsachievementcenter.com

Child's name: _____

## Attendance Policy

Every effort is made to provide an individual therapy time, which is conducive to your child and family schedule. In the event that you do need to cancel we request that you call our office or your therapist directly. Cancellation must be made **24 hours in advance** of therapy session (please see "Cancellation Policy"). If 25% of scheduled appointments per month are missed, a change in your therapy scheduled time **WILL** occur. Rainbow Kids Achievement Center will send you written notification of the change in your schedule, as well as contact you via phone **or** email. Please call our office immediately to schedule a different therapy time. Once you have exceeded the 25% of cancelled visits the therapy time/day you had previously schedule is revoked. Please call the office to re-schedule ongoing therapy time.

Should Rainbow Kids Achievement Center cancel your scheduled visit, every effort will be made to reschedule the missed visit within the month. Sessions cancelled by the parent are not guaranteed to be made up in additional visits. Please note that insurance providers may have attendance policy's, please see individual plan for that information.

I have read and understand Rainbow Kids Achievement Center's Attendance Policy.

_____ _____
Parent/Guardian Signature Date

## Cancellation Policy

Rainbow Kids Achievement Center strives to ensure quality of service for both the child and family along with our commitment to provide service to meet each individual child's needs. Hence, our Cancellation Policy aids us in achieving these high standards.

Cancellation must be made 24 hours in advance of therapy session by either calling Rainbow Kids Achievement Center directly, leaving a message on phone service, or email. Failure to cancel within 24 hours' notice **WILL** result in a $40.00 charge, to be paid directly by family.

I have read and understand Rainbow Kids Achievement Center's Cancellation Policy.

_____ _____
Parent/Guardian Signature Date

30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688 Ph: 949-459-1658 Fax: 949-459-1667 www.rainbowkidsachievementcenter.com

# Authorization to Release and Request Information

Child's name: _____ DOB: _____

In consideration of my participation in this program, I hereby authorize Rainbow Kids Achievement Center to release information and data relative to the participation of my child and myself in the infant-toddler intervention program and/or individual designated therapy and/or early intervention program. I understand that this information will include such items as goals and objectives released only upon the formal request of a concerned community agency (i.e., Regional Center, Insurance, and School Programs). I further authorize Rainbow Kids Achievement Center to request records from concerned community agencies, physicians, insurance companies and prior developmental and/or therapeutic programs.

I hereby authorize Rainbow Kids Achievement Center to release medical, developmental and/or educational information to my private insurance carrier as is required for determination of benefits. I authorize the release of any medical, developmental and/or educational information necessary to process medical claim. I also request payment of benefits to Rainbow Kids Achievement Center.

This authorization will stay in effect until revoked by me.

I have read and understand Rainbow Kids Achievement Center's Authorization to Release and Request Information Policy.

_____ _____

Parent Signature Date

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ACHIEVEMENT CENTER
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# Consent to Participate/Release of Liability

Child's name: _____ DOB: _____

I have consented to participate in this program with the understanding that I am personally responsible for the health, welfare, and safety of myself and my child/children as well as all other's in my care or family during home visits or while on the premises of 30252 Tomas Suite 100, Rancho Santa Margarita, CA, 92688 and during program and or social related activities. I hereby release Rainbow Kids Achievement Center, staff, and any and all others associated with the program from such responsibilities and liabilities.

As the child's parent or legal guardian, I hereby grant permission for the specialist at Rainbow Kids Achievement Center to render to my child requested therapy and/or intervention including evaluations, therapeutic activities, educational activities, and other procedures and/or treatments prescribed by my physician and my child's therapists as is necessary in their judgment.

This consent will stay in effect until revoked by me.

I have read and understand Rainbow Kids Achievement Center's Consent to Participate and Release of Liability.

_____ _____
Parent/Guardian Signature Date

Rainbow Kids
ACHIEVEMENT CENTER
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Child's name: _____

## Grievance Procedures

If a family has a dilemma with any aspect of services from Rainbow Kids Achievement Center, the family or individuals have several options available to pursue a satisfactory resolution. Rainbow Kids Achievement Center strives to establish open, honest communication with each family and to be proactive in responding to family concerns. The IFSP document outlines the priorities for each child and the procedures and time lines in which to accomplish them. Regular IFSP reviews should enable corrections to service provisions. Additionally, if a child is paying privately, billing insurance or has an authorization for services, quality of services provided are kept at the highest standard for Rainbow Kids Achievement Center. If you feel this is not the case, the family then has the responsibility to:

1. Clearly identify the problem or issues, preferably in writing.
2. Family and staff attempt to resolve issue.
3. If program level therapists cannot help to resolve the problem with the family, it may be taken to the director of programs.
4. Family may call the Early Start Coordinator at Regional Center or other support persons at any time in the grievance resolution process and always has the option to call an IFSP meeting. If not coming through the Regional Center of Orange County, the family may call support persons at insurance agency.
5. Corporate level personnel are available to facilitate a resolution.
6. For grievances that extend beyond Rainbow Kids Achievement Center, procedures of the respective agencies or programs should be employed.

I have read and understand Rainbow Kids Achievement Center's Grievance Procedures.

_____ _____
Parent/Guardian Signature Date

## Confidentiality Statement

We, the staff of Rainbow Kids Achievement Center understand and agree that we must hold medical and developmental information in confidence. Further, we understand that the intentional or involuntary violation of the confidential nature of any information may possibly result in punitive action including possible fine or imprisonment. All information between family and staff member of Rainbow Kids Achievement Center is held strictly confidential unless:

1. The patient authorized release of information with a signature
2. Rainbow Kids Achievement Center is ordered by court to release information
3. The patient presents a physical danger to self or others
4. Child abuse/neglect is suspected
5. In these latter two cases, Rainbow Kids Achievement Center is required by law to inform potential victims and legal authorities so that protective measure can be taken.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have rights to privacy regarding my protected health information. I understand that my protected health information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly, as well as obtain payment for services and conduct normal health care operations.

I have read and understand Rainbow Kids Achievement Center's Confidentiality Statement.

_____ _____
Parent/Guardian Signature Date

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Child's name: _____

## Consent to Photograph, videotape, and Audiotape

I hereby authorize Rainbow Kids Achievement Center to photograph videotape and audiotape my child for the purposes of assessment, treatment, education and professional reasons.

Additionally, I authorize Rainbow Kids Achievement Center to photograph videotape and audiotape my child for marketing materials including Facebook, flyers, website and/or special events.

- ☐ I DO NOT consent to my child being photographed, videotaped and audiotaped.
- ☐ I have read and understand Rainbow Kids Achievement Center's Consent to Photograph, Videotape and Audiotape.

_____ _____
Parent Signature Date

## Consent for Emergency Medical Treatment

I (we) the parent(s)/caregiver(s) of _____ authorize staff from Rainbow Kids Achievement Center to seek emergency medical treatment for my child, in the event I (we) am (are) unable to provide such authorization.

I (we) grant permission for staff from Rainbow Kids Achievement Center to summon paramedics or other emergency medical personnel and seek emergency treatment, including emergency medical transfer and removal, and to ensure that all essential needs are provided for at such a facility or by such a provider.

I (we) understand that staff from Rainbow Kids Achievement Center will attempt to notify me (us) immediately in any emergency medical situation.

_____ _____
Parent Signature Date

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# Consent for Parent Observation

Child's name: _____ DOB: _____

I understand that other parents may observe my child in therapy and/or early intervention programing while those parents are with their own child in therapy and/or early intervention programming.

_____ _____

Parent Signature Date

# Consent for Bathroom Release

Child's name: _____ DOB: _____

I authorize Rainbow Kids Achievement Center to allow my child to use the bathroom with the assistance and supervision from Rainbow Kids Achievement Center staff. If my child is not toilet trained, I authorize Rainbow Kids Achievement Center staff to provide diaper changing if it is required during my child's visit at Rainbow Kids Achievement Center. If adequate supplies for diaper changing are not available and not provided by parent, I understand that the session may be suspended until adequate supplies are available.

_____ _____

Parent Signature Date

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Child's name: _____

## Site Waiver

In consideration of my participation in this program, I hereby release Rainbow Kids Achievement Center from physical and general liability while on the premises of 30252 Tomas Suite 100, Rancho Santa Margarita, CA, 92688 and during program related activities. I hereby release Rainbow Kids Achievement Center, staff, and any and all others associated with the program from such responsibilities and liabilities.

I have read and understand Rainbow Kids Achievement Center's Site Waiver.

_____ _____

Parent Signature Date

## Parent Participatory Program

Rainbow Kids Achievement Center is a parent participatory program. We encourage parent participation in whatever therapeutic level 30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688, during your child's scheduled therapy time, prompt pickup is necessary. Our therapy is typically scheduled back to back; therefore, our therapists are expecting to begin treatment with another child immediately after completion with previous child. If parents are tardy in picking up their child, it affects all subsequent therapy sessions. In order to maintain quality therapy and maximize each child's therapy session, it is mandatory you pick your child up at end of therapy time. If you are tardy, **a fee of $1.00 for every minute you are late is immediately payable.** After the second tardy, we reserve the right to discontinue therapy.

I have read and understand Rainbow Kids Achievement Center's Parent Participatory Program.

_____

Parents Signature Date

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# Patient Information

*Insurance*

| | |
|---|---|
| ***Patient's Name:*** | ***Parents Names:*** |
| ***Date of Birth:*** | ***Home Phone Number:*** |
| ***Email Address:*** | ***Parents Work Numbers:*** |
| ***Patient Address:*** | ***Parents Cell Phone Numbers:*** |
| ***Sex:*** Male Female | ***Patients SSI Number:*** |
| ***Patient's Relationship to Insured:*** | ***Referred By***: |
| ***Primary Care Physician:*** | ***What therapy services are you interested in?*** ***OT PT SP ABA*** |

| | |
|---|---|
| ***Employer Information:*** | ***Employer's Address:*** |
| ***Employer's Phone No.:*** | ***Insured's and Responsible Party's Name:*** |
| ***Insured's and Responsible Party's Address:*** | ***Insured's and Responsible Party's Date of Birth:*** |

| | |
|---|---|
| ***Insured's and Responsible Party's Home, Work and Cell Phone No.:*** | ***Insured's and Responsible Party's SSI#*** |
| ***Insured's and Responsible Party's Employer Information:*** | ***Insured's and Responsible Party's Employer Address:*** |
| ***Insured's and Responsible Party's Employer Phone No.:*** | |

**PRIMARY INSURANCE**

| | |
|---|---|
| ***Primary Insurance Company Information:*** | ***Claims Address:*** |
| ***Policy Identification Numbers:*** | ***Eligibility Phone Numbers:*** |
| ***Subscriber's Name:*** | ***Claims Phone Numbers:*** |
| ***Subscriber's Date of Birth:*** | ***Patient Relationship to Subscriber:*** |
| ***Group Name:*** | ***Group Number:*** |
| ***Co-payment:*** | |
| **SECONDARY INSURANCE** | **N/A (*please circle if applicable)*** |
| ***Secondary Insurance Company Information:*** | ***Claims Address:*** |
| ***Policy Identification Numbers:*** | ***Eligibility Phone Numbers:*** |
| ***Subscriber's Name:*** | ***Claims Phone Numbers:*** |
| ***Subscriber's Date of Birth:*** | ***Patient Relationship to Subscriber:*** |
| ***Group Name:*** | ***Group Number:*** |

| |
|---|
| ***Concerns:*** |

*Please attach a copy of the following:*

- *Driver's License*
- *Insurance Card – Front and Back*

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# Client Notice of Financial Responsibility

Child's name: _____ DOB: _____

Please initial each item and sign at bottom

_____ Rainbow Kids Achievement Center will file insurance claims with your insurance carrier. We are currently in-network with several insurance companies. All parents are expected to know and understand their coverage and benefits for therapy and intervention services. Although we will verify insurance eligibility and benefits prior to your first appointment, you may also check your benefits by calling the phone number on your insurance card and speaking with a representative from the insurance company. A quote of benefits from your insurance company is not a guarantee of payments. In the event your insurance chooses not to pay for services rendered, you are ultimately responsible for all charges.

_____ Please provide Rainbow Kids Achievement Center with a copy of your insurance card each time you receive a new card and/or your insurance information changes. Please understand that if your insurance company delays payment or is waiting on additional information before they render payment, and the balance due is past 45 days, the balance is your responsibility and is due immediately.

_____ Deductibles, co-insurance and co-payments are due at the time services are rendered. If payment is not made immediately a $5.00 administrative fee will be added to each payment. In the event that deductibles, co-insurance and co-payments exceed payment by 30 or more days, services will be placed on hold until the balance is paid in full.

_____ Rainbow Kids Achievement Center will answer any insurance related questions you may have to the best of our ability. However, calling your insurance company directly is frequently required. Any follow-up regarding non-payment after our initial appeals process is your responsibility. If payment is not issued by the insurance company within 45 days of initial filing, you are responsible for payment in full for all services rendered. It is then your responsibility to follow up with the insurance company regarding any further appeals.

_____ You are responsible for payment of any no-shows or late cancellations, please see Rainbow Kids Achievement Center Cancellation Policy for all fees - $40.00 fee.

_____ In the event that a check is returned for insufficient funds, there will be a fee of $35.00 due on your account in the addition to the original balance.

_____ Any accounts turned over to our outside collection agency will incur an additional charge of 33% on your balance for administrative fees.

I have read the above and hereby accept all responsibility for the evaluation, treatment and intervention costs incurred by my child. The undersigned certifies that he/she accepts these terms.

_____ _____

Parent Signature Date

_____

Printed Name

30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688 Ph: 949-459-1658 Fax: 949-459-1667 www.rainbowkids-ac.com

## PATIENT INFORMATION

*The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Rainbow Kids Achievement Center will hold information provided by you in strict confidence and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.*

Date: _____ Families Email Address: _____

***** All reports and correspondence will be sent via email and will not be shared with other agencies.**

Patient's Name: _____ Sex: _____
Last First Middle Initial

Address: _____
Street City Zip Code

Date of Birth: _____ Phone: _____

Primary Insured on Insurance Policy _____

DOB _____ SSI# _____

Primary language spoken in the home _____

Current Reason for Referral _____

## PARENT INFORMATION

Father's Name: _____ Father's Employer: _____

Home address: _____
Street City Zip Code

Home Phone #: _____ Work Phone #: _____

Cell Phone # _____ Email Address: _____

Mother's Name: _____ Mother's Employer: _____

Home address: _____
Street City Zip Code

Home Phone #: _____ Work Phone #: _____

Cell Phone # _____ Email Address: _____

Legal Custody/Guardianship: N/A Shared Other

_____

_____

Names and ages of brothers and sisters:

_____ _____

Name Age Name Age

_____ _____

Name Age Name Age

Please indicate any special needs or concerns regarding the other children living in your home

_____

_____

**PHYSICIAN**

Pediatrician: _____

Name Address Phone

Date of last visit: _____

Other Physicians involved in your child's health care _____ Yes _____ No

_____

Name Specialty Phone

**BIRTH HISTORY**

Birth Weight: _____

Gestation/delivery: _____ normal _____ abnormal: _____

Complications during Pregnancy _____ Yes _____ No

Full Term Pregnancy _____ Yes _____ No

How many weeks pregnant _____ NICU Stay: _____ Yes _____ No

Birth Weight: _____ Vaginal Delivery _____ C-Section _____

Gestation/delivery: _____ normal _____ abnormal: _____

Medical Treatment at birth: _____ No _____ Yes

Medications at birth: _____ No _____ Yes: _____

Birth History: (Please explain in detail any marked significance in your child's birth history not mentioned above)

_____
_____
_____
_____

## MEDICAL HISTORY

Immunizations Current: Yes _____ No _____ If no, why?

_____

Immunization History:

| VACCINE | DATE EACH DOSE WAS GIVEN | | | | |
|---|---|---|---|---|---|
| | 1ST | 2ND | 3RD | 4TH | 5TH |
| **Polio (OPV or IPV)** | / / | / / | / / | / / | / / |
| **DTP/DtaP/DT/TD** (Diptheria, tetanus and [acellular] pertussis or tetanus, and diphtheria only) | / / | / / | / / | / / | / / |
| **MMR** (Measles, mumps, rubella) | / / | / / | | | |
| (Required for child care only) **HIB Meningitis** (Haemophilus B) | / / | / / | / / | / / | |
| **Hepatitis B** | / / | / / | / / | | |
| **Hepatitis A** | / / | / / | / / | | |
| **Varicella** (Chickenpox) | / / | / / | | | |

### SCREENING OF TB RISK FACTORS

- ❑ Risk factors not present: TB skin test not required.
- ❑ Risk factors present: Mantoux TB skin test performed (unless previous positive skin test documented).

____ Communicable TB disease not present.

Previous Therapy/Intervention _____ No _____ Yes: _____

(when and what)

Is there a history of major illnesses or hospitalizations _____ No _____ Yes

_____
_____
_____

Other Pertinent Medical History:

_____
_____
_____

Is your child currently diagnosed with a seizure disorder?

_____

If so, what type of seizures?

_____

How often do they occur?

_____

Please specify seizure – emergency plan: _____

_____
_____

Number of Ear Infections _____

Is there a family history of delay? _____ No _____ Yes

_____
_____

Does your child have a specific medical and or developmental diagnosis? ____ No _____ Yes

If so, please explain:

_____
_____

Date of Onset or Diagnosis: _____ Who diagnosed: _____

Allergies: _____

Please describe adverse reactions: _____

Hearing test: Yes ____ No ____ Results: _____

Vision Test: Yes ____ No _____Results: _____

Any Imaging Studies _____ Yes _____ No

_____MRI _____ CT _____ X-Ray

Previous Medical Providers:

_____
_____
_____

**DEVELOPMENTAL HISTORY**

| Developmental Milestones | Age Occurred: |
|---|---|
| Sat without support | _____ |
| Crawled on hands and knees | _____ |
| Stand | _____ |
| Walk | _____ |
| Talk | _____ |
| Language Development: | |
| Cooing | _____ |
| Babbling | _____ |
| Jargon or true words | _____ |
| Phrases/sentences | _____ |
| Conversational speech | _____ |

What is your child able to eat at this time: _____ Limited Diet _____ Special Diet

_____

_____

Does your child demonstrate any of the following difficulties with feeding/oral motor skills?

- ☐ Overstuffing mouth with food
- ☐ Gag/vomit during feeding
- ☐ Frequently drools
- ☐ Food preferences/selective
- ☐ Avoids face washing
- ☐ Avoids tooth brushing
- ☐ Difficulties with chewing skills
- ☐ Spillage of food/drink from their mouth
- ☐ Difficulties with cup and /or straw
- ☐ Food texture preferences

If Yes, Please explain:

_____

_____

_____

Does your child have a history of Reflux _____ Yes _____ No

Was your child breast fed _____ Yes _____ No
Do you have any feeding concerns: _____ Yes _____ No

If Yes, Please explain:

_____

_____

_____

**Self-Help Skills**

| | Independent | Needs Assistance |
|---|---|---|
| Socks | | |
| Shoes | | |
| Shirt | | |
| Pants | | |
| Tying shoes | | |
| Brushing teeth | | |
| Toileting | | |
| Using a spoon/fork | | |
| Zipper | | |
| Buttons | | |

Does your child get easily upset with being moved from one place to the next?
_____Yes _____ No

Does/did your child tolerate tummy time? _____ Yes _____ No

Does your child have regular exposure with crawling or walking up and down stairs?
_____Yes _____ No

Does/did your child walk on his/her toes? _____ Yes _____ No

Does your child fall frequently by tripping or bumping into things? _____ Yes _____ No

Does your child have special equipment – GTT, wheelchair, AFO's, etc.?
_____
_____
_____

How does your child communicate wants/needs (words, gestures, sentences)?
_____
_____
_____

Does your child respond when you call his/her name? _____ Yes _____ No

**BEHAVIORAL HEALTH HISTORY**

Is there a history in your immediate or in the mother's or father's extended family, of the following, and if so who?

| *Yes* | *No* | *Condition* | *Who* |
|---|---|---|---|
| | | Autism Spectrum Disorders | |
| | | Learning Problems/Disabilities | |
| | | ADHD-ADD-Attention Problems | |

| | | | |
|---|---|---|---|
| | | Depressions & Manic Depression | |
| | | Behavior Problems in School | |
| | | Anxiety Disorders | |
| | | Cognitive Impairment | |
| | | Psychosis/Schizophrenia | |
| | | Other Mental Health Concerns | |

Does/did your child have a history of behavioral health treatment?
_____ Yes _____ No

If yes, please provide dates and providers of previous treatment, intervention and responses.

_____
_____
_____

**CURRENT INFORMATION**

Child's overall health _____ Good _____ Fair _____ Poor

Current Weight _____ Current Height _____

Does your child sleep well? _____ Yes _____ No

_____
_____
_____

Does/did your child ever have any problems with feeding, reflux, or breathing?
_____ Yes _____ No

_____
_____
_____

Does your child participate in age appropriate movement activities? (Rolling over, jumping, swinging, riding a bike, etc.) _____ Yes _____ No

_____
_____
_____

Does your child use eye contact and gestures when needing assistance or attempting to communicate? _____ Yes _____ No

_____
_____
_____

Describe any difficulties you have with your child's behavior?

_____
_____
_____

What are your current concerns and what do you expect from therapy/program?

_____
_____
_____

Have you observed your child emit any of the following behaviors: vocal sounds, flapping hands, lining up objects, limited eye contact? _____ Yes _____ No
If yes, please explain

_____
_____
_____

Have you observed your child emit any self-injurious behaviors (examples: banging head on hard objects, eye poking)? _____ Yes _____ No

_____
_____
_____

Have you observed your child emit any unsafe behaviors to self or others (examples: running away, hitting, and throwing objects)? _____ Yes _____ No

_____
_____
_____

Have you observed your child emit any ritualistic behaviors (examples: wearing same clothes every day, talking about one topic, eating limited foods)? _____ Yes _____ No

_____
_____
_____

Please list any spiritual variables that may impact treatment

_____

Please list any cultural variables that may impact treatment

_____

Please list any list any presence or absence of relevant legal issues that may impact treatment

_____
_____
_____

Please list any community resources (support groups, social services, school-based services, Regional Center, other social supports) client is currently utilizing

_____
_____
_____

Please list any other behaviors of concern

_____
_____
_____

Please describe your child's daily routine (include times to wake up, naps, bedtimes, meals, school, etc.).

| | |
|---|---|
| *Morning* | |
| *Afternoon* | |
| *Evening* | |
| *Night* | |

Please list any medications your child is currently taking or has taken for extended periods.

| *Medication* | *Purpose* | *Dosage* | *Dates* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please list all challenging behaviors in the chart below. Please list any additional information/behaviors on the back of this page.

| *Problem Behavior* | *How often does it happen* | *How long does it last* |
|---|---|---|
| 1. | Daily<br>Weekly<br>Monthly | Seconds<br>1-5 min.<br>5-15 min.<br>15-30 min.<br>>30 min. |
| 2. | Daily<br>Weekly<br>Monthly | Seconds<br>1-5 min.<br>5-15 min.<br>15-30 min.<br>>30 min. |
| 3. | Daily<br>Weekly<br>Monthly | Seconds<br>1-5 min.<br>5-15 min.<br>15-30 min.<br>>30 min. |
| 4. | Daily<br>Weekly<br>Monthly | Seconds<br>1-5 min.<br>5-15 min.<br>15-30 min.<br>>30 min. |

Please list your child's favorite toys, food, activities, etc.

_____
_____
_____

Please list any fears your child may have

_____
_____
_____

**EDUCATIONAL HISTORY**

Is your child presently in school? _____ No _____ Yes

Name of school:

_____

Teacher's name:

_____

Grade: _____Is he/she having any educational difficulties? _____

Does your child currently have an IEP? _____ No _____ Yes

Is your child receiving any special help? If so, please list specific disciplines and schedule.

_____

_____

_____

**EMERGENCY INFORMATION**

In case of emergency, please specify 3 people we may contact:

(1)

_____

Name Phone # Relationship

(2)

_____

Name Phone # Relationship

(3)

_____

Name Phone # Relationship

**REFERRAL INFORMATION**

Who referred you to Rainbow Kids Achievement Center?

( ) Doctor
( ) School District
( ) Regional Center of Orange County
( ) Other

**RELEASE OF INFORMATION**

I hereby authorize Rainbow Kids Achievement Center to obtain and use all medical, social, and education reports pertaining to my child, _____ as necessary to evaluate and/or treat my child. This authorization shall remain in effect until my child is formally discharged from treatment or until I have submitted a written statement to Rainbow Kids Achievement Center, which terminates this authorization.

Parent's Signature: _____ Date: _____

## Cancellations Frequently Asked Questions (FAQ's)

**Q:** Who do I contact to cancel my appointment?

**A:** Please call our office at 949-459-1658 to let the front office know. In addition to letting the office know you can contact your therapist if they have provided you with their number and/or email address.

**Q:** How much notice do I need to give Rainbow Kids if I'm cancelling?

**A:** Please give us 24 hours' notice for cancellations. Failure to cancel with at least 24 hours' notice will result in a charge.

**Q:** What do I do if my child is sick and I need to cancel the same day as my therapy session?

**A:** Please contact the office as soon as you know you will not be able to make it due to illness. If your child is sick in the morning and you do not call until the afternoon it will be considered a late cancellation.

**Q:** What is considered a late cancellation?

**A:** Any appointment that is cancelled with less than 24 hours' notice is considered a late cancellation and will result in a late fee of $40.00.

**Q:** How do I cancel an appointment that is back to back with two different therapists?

**A:** Please call our office as soon as you know you will not be able to make it. You can also contact all your therapists if they have provided you with contact information.

**Q:** If I cancel with my therapist directly will they tell the other therapists my child is seeing?

**A:** No, you need to contact our front office and they will inform all your therapists. You may also let all your therapists know individually.

**Q:** What is the procedure if I am running late for a session?

**A:** If you are running late please contact our office so the therapist doesn't think you are not coming and leave. If you show up late your appointment time is not extended and will still end at the scheduled time. After 15 minutes into the scheduled appointment time, with no phone call, the appointment is cancelled and considered a no show.

**Q:** What if I cannot do any makeup times the therapist offers but I would like one?

**A:** We will do our best to find a time to do a makeup, please let the front office and your therapist know so we can work on it.

**Q:** I do not understand the 75% policy, what is it?

**A:** Our policy is that to continue therapy at your scheduled time you must attend 75% of your visits each month. If you have four scheduled appointments but only come to two of them then you have not met this requirement as it is only meeting 50% of the time. At which time we will need to move your schedule to a time that better suites your needs. If a better time is not open, then we will put you on the wait list for a time that better meets your needs.

**Q:** Does cancelling effect my insurance coverage?

**A:** We do note in your child's report the number of sessions attended and some insurances will reduce your next contract visits limit.

**Q:** When can I do a make-up session?

**A:** Some insurances allow you to do a makeup session anytime within your authorization dates. Those insurances are Kaiser, Monarch, and all PPO's. Other insurances that limit you to make-ups sessions only within that same week are Easter Seals and Regional Center.

**Q:** What do I do if I'm late picking up?

**A:** Please call and let us know if you will be late. We ask that parents return 10 minutes before the end of their session to have time to talk with the therapist and hear about their child's session. For every minute that you are late picking up there is a $1 charge. For example, you show up 3 minutes late then there is a $3 charge due at that time.

**Q:** What do I do if I have concerns with my therapist?

**A:** Please let the front office know if you have any concerns or are interested in changing therapists. We understand that some people have different personalities or styles and a change can be beneficial for your child.

**Q:** What happens when my therapist cancels excessively?

**A:** Please let the front office know if you feel that your therapist has cancelled excessively, and we will work to maintain continuity of therapy.

# Emergency Plan