

**Patient Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #:\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Home phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex (circle one): Male Female E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who should we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incase of emergency, who should we contact?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance

Person responsible for account:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Insurance Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**School and therapy services**

School/program currently attending:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Present grade:\_\_\_\_\_\_\_\_

Special services received in school: \_\_\_ OT \_\_\_\_ PT \_\_\_\_ Speech therapy \_\_\_\_\_ Behavioral \_\_\_\_\_\_\_

Special education:\_\_\_\_\_\_\_ Other services\_\_\_\_\_\_\_\_\_\_\_\_

Does your child teacher have concerns about your childs development in any of these areas:

\_\_\_\_ Motor Skills \_\_\_\_\_\_ Social skills \_\_\_\_\_\_\_\_Self help skills\_\_\_\_\_\_Cognitive skills/learning abilities

Additional comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a IEP from school? Yes\_\_\_\_ No\_\_\_\_\_ What does it cover?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Relevant Medical Information**

Physician currently involved in your child’s care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current diagnosis/infections:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent hospitalizations:\_\_\_\_\_ No \_\_\_\_\_Yes If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent surgery:\_\_\_\_\_\_\_ No\_\_\_\_\_Yes If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications your child currently takes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special equipment your child uses: \_\_\_splint\_\_\_\_braces\_\_\_walker\_\_\_\_\_crutches\_\_\_\_\_wheelchair\_\_\_other

Previous psychological study:\_\_\_No\_\_\_Yes, Results of testing indicate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Learning Disability \_\_\_\_Attention Deficit Disorder \_\_\_\_\_\_\_ Hyperactivity \_\_\_\_Intellectual Disability

\_\_\_\_ Developmental Delay \_\_\_\_\_ Autism/Pervasive Developmental Disorder\_\_\_\_ Behavioral Disorder

Please check all that apply to your child (previous or current):

\_\_\_\_\_Seizures \_\_\_\_G-tube\_\_\_\_\_\_Food allergies \_\_\_\_\_\_\_Hearing aids\_\_\_\_\_\_Wears glasses

\_\_\_\_Latex sensitivity \_\_\_\_\_\_\_Hearing difficulty \_\_\_\_\_\_\_Vision problems \_\_\_\_\_\_\_Ear infections



**Assigment and Release**

I hearby authorize payment to Holistic Blossom Pediatric Therapy for all insurance benefts otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services on my behalf or my dependents.

I authroize the above provider of services in the office to release the informaton required to secure payment of benefits. I authroze the use of this signature on all submissions.

**Signature of responsible party**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



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

Thank you for choosing Holistic Blossom Pediatric Therapy for your child’s therapy needs. Our mission is to “Exceed Expected Expectations”.

**Filing Insurance**

As a courtesy, Holistic Blossom Pediatric Therapy will file a claim to your primary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Holistic Blossom Pediatric Therapy will call on any unpaid claim(s) at least every 30 days. After 90 days without payment, the family will be responsible to begin paying on their account balance and private pay future appointments in order to ramain on the treatment schedule.

**Copays, decutables and coinsurance**

All co pays are due at the time services are rendered. For your convienece, we accept Visa, MasterCard and Discover in the office or over the phone. A reciept will be provided.

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

I give my consent to any appropriate and medically necessary procedures, services or therapies that would be included in the treatment as required by the primary physician or supervised staff for the above named person.

I understand and acknowledge that I am finacially responsible for all charges incurred during the treatment at Holistic Blossom Pediatric Therapy, whether or not paid by insurance, rendered for the above named person.

**Parent/Guardian Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Print Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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

I authorize disclosure of my childs’s protected health information only in the specific manner, for the names reason, and to the specific individuals described below:

Please release information to:

Holistic Blossom Pediatric Therapy

525 Woodlands Square Blvd.

Suite 250

Conroe, TX 77384

I autohorize Holistic Blossom Pediatric Therapy to disclose the following information:

* All the below
* Evaluation Report
* Treatment session notes
* Billing records
* Complete copy of medical record
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree that this authroization will be valid and in effect for 12 months after completing this form. I can revoke consent at anytime, providing that the revocation is in writing.

**Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to the patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**HIPPA Compliance**

**Patient name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This concent is given freely with the understanding that:

1. Any and all records, wheather written or oral or in electronic format, are confidential and can not be disclosed for reasons outside of treatment, payment or health care operations without my prior written autorization, expect otherwise provided by law.
2. I have the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment payment or health care operations, be restricted. I also understand that the practice and I must agree to terminate any restrictions in writing on the use and disclosure of any Protected Health Inforamtion, which have been previosly agreed upon.

Can we contact other family members or other individuals about the patient’s general information and diagnosis? \_\_Yes \_\_No

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If yes, please list whom we may inform about the patients general information and diagnosis. Yes/ No

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Phone: | Name: | Phone  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Can we contact family members or other individuals, about the patient medical condition only in emergency? Yes/NoIf yes, please list name and phone number.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Phone: | Name: | Phone: |

 |
| Can we contact you via telephone number?If yes, please provide number where we can call about the patients appointment, test results or additional helath information.

|  |  |
| --- | --- |
| Home: | Alternative phone: |

 |

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The undersign certifies that they have read the goregoing, received a copy thereof, and is the patient or patient’s legal representaives to execute the above and accept its terms.

Signature of legal guardian/parent/patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



**Cancellation Policy**

**Patient name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our mission is to provide Providing treatment through a general quality view of mind, body, and spirit, for increase engagement in developmental milestones and daily occupation. Evidence based care and treatment to increase overall wellness and family dynamics.

We are founded on the important premise that carryover of new skills is maximized when the skills are learned in a natural, caring, calm environment, and designed to mirror the experiences that the typically developing child encounters within his or her community.

Holistic Blossom Pediatric Therapy will enforce the attendance policy for clients who do not show or fail to cancel a therapy session with at least 24 hours prior to notice, a $30 no show fee will be required. In order to avoid being discharged from therapy program, your child will need to maintain 85% attendance. Notification or family obligations are requested at least two weeks prior to the expected absence, to facilitate rescheduling appointment (s).

**Rescheduling Appointments**

If your therpaist is ill or on vacation, Holistic Pediatric Therapy will reschdule appointments for continuation of services. We will make every effort to re-schedule at your regular schedule appointment time. If this can not occur, Holistic Pediatirc Therapy will provide and alternate appointment time that best correlates with your schedule.

*Thank you for the opportunity to work with you and your child.*

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

Signature of Patient, Parent or Legal Guardian **Date**