185 Cornerstone Lane
Hot Springs, AR 71913
Phone: (501) 525-4855 Fax: (501) 525-5812
admin@lbcec.com

Date received: _____

Contact Information						
Child's Name		Sex	Date of Birth			Age
Parent(s) / Guardian(s) Name(s)				Child's SSN		
Address						
City			State			Zip Code
Email						
Phone #	Cell		Work		Home	
Physician Name		Physician Phone Number		Physician Address		
Insurance Company Name				Policy Number		
School Attending				Grade/Level		

General Information						
Were there any complications, illness, or stress during pregnancy?	☐ No	☐ YES If yes, Please Specify:				
Were there any complications during labor or delivery?	☐ No	☐ YES If yes, Please Specify:				
Please specify the conditions of your child's birth (circle that all apply)	Vaginal ☐	Forceps ☐	Vacuum ☐	C-Section ☐	Premature ☐	Full-Term ☐
What was your child's birth weight?	lbs oz					
Please indicate age/sex of any siblings						
If child has any medical diagnoses, please specify:						

Has/Does your child receive other interventions? (check all that apply)	☐ No	Yes:				
		☐ Occupational Therapy	☐ Physical Therapy	☐ Speech Therapy	☐ Developmental Therapy	☐ Mental Therapy
		How Long?	How Long?	How Long?	How Long?	How Long?
Does your child have any allergies?	☐ No	☐ Yes Please Specify:				
Does your child have a history of ear infections?	☐ No	Yes: How many? At what ages?				
Does you child currently take any medications?	☐ No	☐ Yes Please Specify:				
Does your child have a history of seizures?	☐ No	☐ Yes Please Specify:				
Has your child experienced any major injuries or hospitalizations?	☐ No	☐ Yes Please Specify:				
Does your child wear glasses/hearing aid?	☐ No	☐ Yes				

Please note the approximate age when your child achieved the following skills:	Sitting	Belly Crawling	Knee Crawling	Cruising	Walking	First Words	Talking
	Hopping	Jumping	Skipping	Running	Ride a tricycle	Riding a 2-wheel bike	Jumps rope

Where does your child attend pre-school or school?	Home School	Daycare	Special Needs Pre-School	Regular Education Class	Special Education Class	Other:

Does your child exhibit a hand preference?	No	Yes, please circle:	
		Right ☐	Left ☐
		Established at what age?	

Getting to Know Your Child

Please check the appropriate box next to the following items which describe your child best when thinking of the statement written.

**Use the notes column to give more detail when necessary.*

	Always	Sometimes	Never	Does Not Apply	Notes:
Your child prevents you from attending family gatherings / social gatherings due to their behavior.	☐	☐	☐	☐	
Your child has difficulty when their routine is interrupted.	☐	☐	☐	☐	
Your child's behavior prevents you from eating out at restaurants.	☐	☐	☐	☐	
Your child does not like loud noises, crowded rooms, unpredictable environments, sporting events.	☐	☐	☐	☐	
Your child prefers not to be touched.	☐	☐	☐	☐	
Your child does not exhibit safety awareness.	☐	☐	☐	☐	
Your child has difficulty sitting still or standing in a line	☐	☐	☐	☐	
Your child exhibits aggressive behavior when playing with others or towards themselves.	☐	☐	☐	☐	If so, describe:
Your child has tantrums.	☐	☐	☐	☐	If so, describe and how long do they last?
Your child is easily frustrated, anxious or overwhelmed.	☐	☐	☐	☐	
Your child is overly dependent and/or clingy to parents / caregivers.	☐	☐	☐	☐	
Your child escalates easily to a loud cry / scream.	☐	☐	☐	☐	
Your child has difficulty with transitions.	☐	☐	☐	☐	If so, describe:
Your child makes good eye-contact when you are talking to them.	☐	☐	☐	☐	
Your child responds when you call their name.	☐	☐	☐	☐	
Your child lacks a fear of strangers.	☐	☐	☐	☐	
Your child plays well with other children.	☐	☐	☐	☐	
Your child takes care of their toys and is able to clean up after themselves (age-appropriately).	☐	☐	☐	☐	
Your child loves to crash into things.	☐	☐	☐	☐	

	Always	Sometimes	Never	N/A	
Your child is a picky eater.	☐	☐	☐	☐	If so, describe:
Your child does not tolerate tags in their clothing, seams in socks or other similar irritants.	☐	☐	☐	☐	If so, describe:
Your child will not walk barefoot in grass or other textured surfaces.	☐	☐	☐	☐	If so, describe:
Your child is toilet trained for bladder.	☐	☐	☐	☐	
Your child is toilet trained for bowel.	☐	☐	☐	☐	
Your child seems like they are choking, or have difficulty with drinking.	☐	☐	☐	☐	If so, describe:
Your child has difficulty chewing foods and/or swallowing.	☐	☐	☐	☐	If so, describe:
Your child can use a fork and spoon appropriately.	☐	☐	☐	☐	
Your child often puts toys, objects in their mouth.	☐	☐	☐	☐	
Your child grinds their teeth.	☐	☐	☐	☐	
Your child often will cover their ears or act irrationally to loud noises / objects.	☐	☐	☐	☐	If so, describe:
Your child displays a high pain tolerance or does not exhibit a pain response when compared to other children.	☐	☐	☐	☐	If so, describe:
Your child can get undressed by themselves.	☐	☐	☐	☐	
Your child can manage snaps, zippers and button fasteners on clothing.	☐	☐	☐	☐	Describe any issues:
Your child tolerates and participates well with grooming activities (brushing teeth, bathing, hair brushing/combing, face washing, hair cuts, nail trimming, blowing nose).	☐	☐	☐	☐	Describe any issues:
Your child enjoys all the playground equipment when they go.	☐	☐	☐	☐	Describe any issues:
Your child can communicate their needs.	☐	☐	☐	☐	***Circle the most frequent way your child communicates:*** Verbal (words) ◯ Gestures (e.g. pointing) ◯ Crying / Tantrums ◉

If your child uses any atypical repetitive behaviors, circle which behaviors are demonstrated:					
	Hand flapping	Rocking	Head banging	Jumping	Smelling
	Breath holding	Humming	Self-talk	Biting	Mouthing objects
	Visual fixing	Spinning	Teeth grinding	***Other:***	

Other

What is / are the hardest times of day and why?	
*In summary, what **primary concerns or goals,** do you have regarding your child's behavior or development?*	

185 Cornerstone Blvd., Hot Springs, AR 71913
ph: 501-525-4855 **fax:** 501-525-5812 **email:** admin@lbcec.com

HIPPA POLICY AND PROCEDURE FOR PHI STORAGE

This policy was established 7/1/09

All Protected Health Information (PHI) will be stored as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), its implementing regulation sat 45 CFR Parts 160 and 164 (65 Fed. Reg. 82462 [Dec. 28, 2000]) ("Privacy Rules"), as amended (67 Fed. Reg. 53182 [Aug. 14, 2002]), and state law that provides greater protection or rights to patients than the Privacy Rules.

All hard copies of evaluations, treatment orders, protocols, treatment notes, correspondence from physicians and other service providers will be stored in a locked filing cabinet. Data will be kept in secure location for no less than 5 years.

All electronic PHI will be stored on a password protected computer. All emails and communications with other healthcare personnel and families will be stored in a password protected file.

In the case that PHI is accidentally lost, misplaced or stolen, the affected individuals will be notified within 7 business days.

Little Bitty City Therapeutic Services

185 Cornerstone Blvd., Hot Springs, AR 71913

ph: 501-525-4855 **fax:** 501-525-5812 **email:** admin@lbcec.com

HIPAA GENERAL CONSENT/ AUTHORIZATION FOR TREATMENT

I hereby give my consent for Little Bitty City Therapeutic Services, LLC to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Personal Health Information is as follows:

> I*nformation that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.*

This Protected Health Information could include information that is Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I have been informed that my Health Care Provider has adopted a complete statement of its privacy practices, which are contained in Little Bitty City Therapeutic Services, LLC – Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices and have had an opportunity to review them and ask any questions concerning them before signing this HIPAA Consent. I understand that my Health Care Provider has the right to change them at any time without advance notice to me. I can request a copy of my Health Care Provider's latest Notice of Privacy Practices by calling the office, stopping by and picking up a copy, stopping by and reading the Notice that is posted in my Health Care Provider's waiting room, or asking that my name be put on a list to be mailed a copy should my Health Care Provider make changes to the Notice of Privacy Practices. I understand that I have the right to not give this consent, however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.

I understand that I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request. I understand that if my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.

I understand that I have the right to revoke my consent, however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

Signing below serves as consent for Little Bitty City Therapeutic Services, LLC to conduct Occupational Therapy, Speech Therapy or Physical Therapy screenings, Mental Health evaluation and/or treatment with your child/self. This treatment may be delivered in person or via teletherapy when deemed appropriate by the evaluating therapist. These services can be carried out by a licensed therapist (OT/SLP/PT) or a licensed therapist assistant (COTA/PTA/SLPA).

_____	_____
Child's Printed Name	Guardian's Printed Name / Phone Number
_____	_____
Child's SSN / Date of Birth	Guardian's Signature
_____	_____
Child's Pediatrician Name	Date

Little Bitty City Therapeutic Services

185 Cornerstone Blvd., Hot Springs, AR 71913

ph: 501-525-4855 **fax:** 501-525-5812 **email:** admin@lbcec.com

Attendance Policy

To all of our patients: Little Bitty City Therapeutic Services is dedicated to providing your children with outstanding therapy and care. We have been experiencing a high number of cancellations within our practice. We know that just as your care is important to us, it is even more important to you. When clients cancel or do not show for appointments, the care being provided suffers in terms of progress. It is crucial to show progress and appropriate level of treatment to entities funding these services. We have created a policy to ensure the quality of services are being performed within our realm of practice.

Please understand that a last minute cancellation or "no show'' does not allow us enough time to accommodate another patient. Because the time we allot for you is valuable, we ask that you please provide our office or therapist at least 24 hours notice if you must cancel or reschedule an appointment. Once cancellation is made, another scheduled appointment must be made within 48 hours of cancellation and made up within in 10 days of original service date.

It is now our policy that a $40.00 non-refundable charge for any appointment that is canceled, and not rescheduled, will be charged. After three "no shows" or cancellations we reserve the right to discharge a patient from our practice.

We do offer a complimentary reminder or e-mail of scheduled appointments but request that you keep a primary reminder to ensure that the visit is attended. This automated service does require initial sign-up.

Your funding source will not cover the additional charges. You must make payment before you are able to continue treatment.

We understand that everyone's time is valuable and we ensure that we are providing services in a timely manner.

Thank you for understanding. We look forward to providing continued exceptional care to you or your child(ren).

_____
Patient – printed name

_____
Guardian – printed name

_____
Date

_____
Guardian/Parent Signature

Little Bitty City Therapeutic Services

185 Cornerstone Blvd., Hot Springs, AR 71913

ph: 501-525-4855 **fax:** 501-525-5812 **email:** admin@lbcec.com

RELEASE OF INFORMATION

Patient Name: _____ Parent/Guardian Name: _____

Date of Birth: _____ Patient Age: _____

Address: _____

☑ Consent to release information **FROM** PCP

TO Little Bitty City Therapeutic Services Therapy, LLC

I hereby authorize Little Bitty Therapeutic Services Therapy, LLC to obtain information, orally and in writing, to include all pertinent medical, psychological, and educational data from the following sources:

_____

_____

This information shall include: PMH

☑ Consent to Release Information **TO** a Third Party

FROM Little Bitty City Therapeutic Services Therapy, LLC

I hereby authorize Little Bitty City Therapeutic Services Therapy, LLC to disclose information, orally and in writing, to include all pertinent medical, psychological, and educational data from the following sources:

PCP

_____

_____

This information shall include: PMH

_____

Date

_____

Guardian Signature

_____

Relationship to Child

_____

Printed Name

Submit

_____

Witness