Initial Intake OT / ST / Both

(please circle above)

BOOST Kids PEDIATRIC THERAPY

Child's legal name:_____ Nickname: _____

Child's DOB: _____ Parent name(s): _____

Medical History

Pregnancy and birth history/complications (including NICU stay): _____

_____

Type of delivery: caesarian / vaginal / breech Length of pregnancy: _____

Current Medications: _____

Allergies: _____

Any previous surgeries, illnesses, hospitalizations? _____

_____

Formal Diagnoses: _____

Specialist(s) seen: _____

Previous therapies: _____

Current therapies (including EI or IEP): _____

Date of most recent hearing exam: _____ Outcome: _____

Date of the most recent vision exam: _____ Outcome: _____

Social History

Living with (include all household members and sibling ages): _____

_____

Provide any additional information regarding significant caregivers (birth parents, foster parents, nanny, grandparents) previously or currently involved in the child's life: _____

_____

Daycare/School: _____ Grade: _____

Favorite toys/games/activities: _____

Developmental History

At what age did the child sit alone? _____ At what age did the child crawl? _____

At what age did the child walk? _____ At what age did the child use first words? _____

At what age did the child combine words? _____ At what age were solid foods introduced? _____

At what age were solid foods (including purées and baby foods) tolerated? _____

Main caregiver concerns: _____

Main pediatrician concerns: _____

Main teacher concerns: _____

BOOST Kids
PEDIATRIC THERAPY

Areas of concern for occupational therapy - please check all that apply

____ fine motor skills & grasp patterns
____ visual motor skills (coloring, drawing, cutting)
____ handwriting
____ motor planning (executing new tasks)
____ self-care skills (dressing, grooming)
____ eating habits/behaviors (picky eating, refusing to try new foods)
____ self-regulation
____ social skills / engagement
____ strength and endurance
____ sensory modulation / processing
____ attention and focus
____ coordination, posture, or balance

Areas of concern for speech and language - please check all that apply

____ Articulation (producing speech sounds)
____ Difficulty following MOST directions
____ Difficulty following multistep directions containing concepts of time or location
____ Difficulty responding to simple questions (who/what/where/when etc.,)
____ Difficulty understanding verbal instructions
____ Listening comprehension
____ Difficulty formulating simple sentences
____ Difficulty asking/answering questions
____ Initiating conversation with peers
____ Fluency (stuttering)
____ Reading comprehension
____ Responding to social cues

Is there a family history of speech or language disorders? Yes No

If yes, explain: _____

At what age did you or your child's pediatrician/educator notice and/or express concerns related to speech/language development? _____

Is your child aware of, or become frustrated by, his/her communication difficulties? Please explain.

_____

Does your child currently use any type of communication device? _____

If your child is under 4, approximately how many words do you believe your child has?

Can your child produce sentences with the following word lengths?

2 words	Yes	No	4 words	Yes	No
3 words	Yes	No	5+ words	Yes	No

If not currently using words, how does your child communicate? (ex: guiding, outbursts/meltdowns, completing tasks independently, pointing/gestures) _____

_____

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PEDIATRIC THERAPY

Client Contact and Insurance Information and
Acknowledgement of Notice of Privacy Practices

Patient's Legal Name: _____ Patient DOB: _____

Parent / Guardian Name(s): _____

Patient's Address: _____

City: _____ Zip: _____

Parent / Guardian Phone: (___) _____ Alternate phone: (___) _____

Email: _____ Subscribe to BOOST Kids newsletter? **Y N**

Health Insurance: _____

Member ID: _____ Group #: _____

Benefits Phone Number: _____

Policy holder name: _____ Relationship to child: _____

Policy holder address: _____ Zip: _____

Policy holder phone number: _____

Employer: _____

Secondary Insurance: _____

Member ID: _____ Group #: _____

Referring Physician: _____

Physician's Practice Name: _____

Physician office phone number: _____

I consent to necessary examination procedures and/or treatment for my child by BOOST Kids licensed occupational and/or speech therapists. Initial: _____

I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to BOOST Kids, LLC for services provided and claimed.
BOOST Kids will submit claims to your insurance, but we do NOT guarantee coverage or payment for services. You will be billed for any portion of treatment not covered by your insurance provider. It is ultimately the responsibility of the parent/guardian to understand your child's specific insurance policy and coverage for therapy services.
Initial: _____

I have been given a copy of BOOST Kids, LLC Notice of Privacy Practices, will review it and keep it on file.
Initial: _____

I hereby give permission for images of my child, _____, captured at BOOST Kids, through video and photo, to be used solely for the purposes of BOOST Kids, LLC promotional material and publications, and waive any rights of compensation or ownership thereto. **Yes** **No** Initial: _____

Parent / Guardian Signature: _____ Date: _____

BOOST Kids Attendance Policies

Updated and effective August 1, 2025

Our attendance policy is structured and implemented in order to provide the most consistent and effective treatment to your child while servicing as many families as possible with the therapy services they need. Failure to comply with the attendance policy outlined below prevents continuity of care, limits progress toward treatment goals, and does not allow for as many children as possible to be scheduled with our staff during our available office hours.

Please read thoroughly and sign and date below to acknowledge receipt and understanding of the updated BOOST Kids attendance policies and the potential consequences of being unable to comply with the company policies that have been set to ensure the highest quality of care possible.

1. Patients scheduled for recurring weekly or bi-weekly appointments are *allowed 5 absences in any 6 month period*. Rescheduling of appointments will be expected within a week of the missed appointment in all non-emergency situations (vacation, alternate appointment or scheduling conflicts, transportation or child care changes, etc.) in order to maintain the required attendance rate. Appointments rescheduled the week prior to or week following the initially scheduled appointment will NOT count as an absence.

   We will make every effort to reschedule with your child's primary therapist, however some of our therapists work part-time and/or have fully booked schedules. If we are unable to reschedule with your primary therapist, your child will be rescheduled with another therapist in the office. We will ensure that the treating therapist has up to date information on your child's preferences, needs, intervention strategies, and treatment goals. _____ **Initial**

2. Cancellations: Caregivers are responsible for notifying the BOOST Kids office at (205) 767-9207 at least 48 hours prior to their scheduled appointment if they have a previously scheduled conflict or vacation. ***Cancellations due to non-emergency situations that are made less than 24 hrs before the appointment time will be considered a Late Cancel and will result in a $75 fee.***

   *If you must cancel with less than a 24 hour notice due to illness or an emergency situation, please email your therapist directly AND leave a voicemail on the office phone.
   *If a household member is sick, preventing attendance to your child's scheduled appointment, we will offer to reschedule or provide a telehealth appointment in order to limit absences . _____ **Initial**

3. No-Shows: ***If you do not notify the office of an absence, the visit will be marked as a "no-show". A $100 fee will be charged for all No Show appointments.*** Two consecutive OR three total "no-shows" will automatically result in the removal of your child from their ongoing weekly appt times. _____ **Initial**

4. Tardiness: Please call the office if you will be 10+ minutes late to your appointment. If you are more than 15 minutes late to a scheduled appt, it may need to be rescheduled. If unable to reschedule, being 15+ minutes late will be considered a No Show and will result in the $100 no-show fee. _____ **Initial**

5. Plug-In Status: If your child has 5 absences in a 6 month period OR has 2 consecutive or 3 total no-shows (including tardies), he/she will be removed from their weekly appointment time. You may have the option to move to "Plug-In Status" and call the office each Monday to schedule an appointment in the openings we have available that week. _____ **Initial**

* Clients will be eligible to return to ongoing appointments after a 90 day period, waitlist dependent
* No-show / late cancellation fees are the responsibility of the client and are not eligible for reimbursement through your insurance provider or any 3rd party payer.
* AL Medicaid does not allow for fees to be collected due to missed appointments. Medicaid clients that fall below the attendance rate OR no-show multiple appointments will have notifications sent to Medicaid and their pediatrician.

Client Name: _____ DOB: _____

Caregiver Signature: _____ Printed Name: _____ Date: _____

BOOST Kids
PEDIATRIC THERAPY

RESPONSIBLE PARTY FORM

Any service rendered at BOOST Kids that is not covered by your child's insurance plan, will be the responsibility of the "responsible party" listed below. Please refer to the *Insurance Benefits Verification Guide* to fully understand your specific insurance plan's coverage for speech and or occupational therapy services *prior* to your child's first appointment at BOOST Kids.

We will verify insurance eligibility within 1 week of scheduling your child's evaluation. We do not verify insurance eligibility on a daily or weekly basis. If your child receives services on a date or multiple dates when they do not have active insurance coverage, the "responsible party" will be responsible for all charges at our private pay rates.

We will make at least 3 attempts to contact you via phone and email to collect any outstanding balances. Any outstanding balance greater than 6 months may be sent to a collection agency. In the event that the account would need to be assigned to an outside collection agency, all associated fees, such as, but not limited to: reasonable collection fees, attorney fees, and court costs will be the responsibility of the "responsible party".

Client Name:_____ **Date of Birth:**_____

The responsible party for services rendered at BOOST Kids is:

Legal Name: _____

Relation to Client: _____

Date of birth:___/___/_____ SSN: _____

Address: _____ Ste/Unit:_____

State: _____ Zip: _____

I understand that services not covered by my child's insurance plan at the time of service, will have to be paid in full by the responsible party listed above.

If my child has a change of insurance, I will provide BOOST Kids (by email or in person) with the new insurance number and insurance card as soon as possible to avoid unnecessary private pay charges. If our office is not provided with the new insurance information (including policy holder name, date of birth and ID numbers) within 30 days of the new insurance plan's active date, "responsible party" will be responsible for all charges incurred during that time period.

Parent/Guardian Signature: _____ Date: _____

BOOST Kids
PEDIATRIC THERAPY

Credit Card Authorization Form

BOOST Kids holds a client credit card on file to charge for all patient responsibility payments, including: co-payments, co-insurances, deductibles, private pay payments, no-show fees, etc. We do NOT accept cash or check payments in the BOOST Kids office. Patient responsibility payments are due at the time of service, and will be made via the credit card listed below through a secure HIPPA compliant and PCI secured system. You will be emailed a receipt for every transaction billed to this card.

Please provide the credit card information you would like your patient responsibility payments to be billed to. Payments are typically charged within 24 hours of your appointment. Please notify us in writing or request a new credit card authorization form if you would like to change your primary method of payment at any point in the future. Failure to update your billing information in a timely manner, that prevents charges from being applied to your account, will result in a $20 administrative fee. Thank you!

Client (child's) Name: _____

Cardholder Name: _____

Relation to client: _____

PLEASE FILL IN ALL REQUESTED INFORMATION BELOW AND ATTACH A COPY OF YOUR CREDIT CARD AND DRIVER'S LICENSE

CARDHOLDER'S NAME: _____

CREDIT CARD BILLING ADDRESS: _____

City: _____ State: _____ Zip Code: _____

CREDIT CARD: Mastercard___ Visa ___ American Express ___ Discover___

CREDIT CARD NUMBER: _____

EXP.DATE: _____ CVV#: _____

PHONE NUMBER: _____ DRIVER'S

LICENSE NUMBER: _____ STATE: _____

I hereby authorize BOOST Kids to charge my credit card account for all patient responsibility payments not paid via check at the time of service.

Card Holder's Signature: _____ Date: ___/___/____