NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

Make sure that protected health information (PHI) that identifies you is kept private.

Give you this notice of our legal duties and privacy practices with respect to health information.

Follow the terms of the notice that is currently in effect.

We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we?mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard, because other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word treatment includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1.Session Notes

We do keep Session notes and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For our use in treating you.

b. For our use in training or supervising associates to help them improve their clinical skills.

c. For our?use in defending ourselves in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate our compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the session notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As health care providers, we?will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As health care providers, we will not sell your PHI in the regular course of our business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1.When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2.For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3.For health oversight activities, including audits and investigations.

4.For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.

5.For law enforcement purposes, including reporting crimes occurring on our premises.

6.To coroners or medical examiners, when such individuals are performing duties authorized by law.

7.For research purposes, including studying and comparing the patients who received one form of care versus those who received another form of care for the same condition.

8.Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9.For workers' compensation purposes. Although my preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.

10.Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with us. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others: We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1.The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say no if we believe it would affect your health care.

2.The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out- of-pocket in full.

3.The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable request.

4.The Right to See and Get Copies of Your PHI. Other than session notes, you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.

5.The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.

6.The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say no to your request, but we will tell you why in writing within 60 days of receiving your request.

7.The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice goes into effect on the date of signature below.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By sign below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Parent/Guardian Signature: _____

Date: _____

INFORMED CONSENT FOR THERAPY

I hereby request and consent to Great Adventures Therapy to perform treatment and care for my child as prescribed by a physician and/or recommended by a Speech-Language Pathologist.

I understand and am informed that, as in the practice of medicine, speech language therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my child's condition prior to treatment.

I acknowledge and agree that a parent or legal guardian must be present in the office?during each treatment session.

I consent and authorize Great Adventures Therapy to administer treatment under the direction and supervision of a certified Speech-Language Pathologist.

I understand that all service payments are due at the time of service, and that some therapy may not be covered by insurance. Great Adventures Therapy will alert me as soon as possible about any portion of payment that is not covered, and I understand that payment is due immediately upon receipt of that information.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with a member of Great Adventures Therapy if I chose.

I agree to hold Great Adventures Therapy harmless for claims or damages in connection with treatment. This is a contract between myself and Great Adventures Therapy, and I understand that it is also a release of potential liability.

Parent/Guardian Signature: _____

Date: _____

ATTENDANCE/CANCELLATION POLICY

Attendance and participation in therapy, along with complete compliance with any associated home programs, are essential for therapeutic success.

While Great Adventures Therapy understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or no shows. Your therapy appointment with our therapists will be a recurring appointment; we ask that you schedule all other medical appointments outside of your therapy appointment at our facility.

Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment.

The full amount for therapy may be charged if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.

- If cancellations are made less than the required 24 hours.
- If the client fails to show up for a scheduled appointment.
- If there is a pattern of scheduling difficulty resulting in a decrease monthly average for attendance.

If you cancel/are late for two (2) scheduled appointments within the same month, fall below an average of 75% attendance, or demonstrate a pattern of scheduling difficulties, Great Adventures Therapy will reserve the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time. If you are 15 minutes late to your appointment, Great Adventures Therapy will reserve the right to cancel the appointment, as time remaining does not allow for therapy to take place.

If you fail to appear for an appointment ("no show") without providing the appropriate advance notification for two (2) or more appointments within the same month, Great Adventures Therapy will reserve the right to cancel all upcoming appointments and to no longer offer services to you as a client.
In the event that your therapist cancels a scheduled session, this will be communicated with you in a timely manner as we are able. If scheduling allows, you will be given the option to make up the missed session if you choose.

INCLEMENT WEATHER POLICY

In the event of inclement weather, Great Adventures Therapy will notify patients of closures/delays via phone/email and on our social media sites as early as possible. You may sign up for county-wide information at WBIR.com if you choose.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Parent/Guardian Signature: _____
Date: _____

INSURANCE INFORMATION

Please provide accurate insurance information so that we may submit claims to your insurance company for dates of service in a timely and effective manner. If you have secondary insurance, please include that information as well.

**If you have Medicaid/TennCare but also have another primary insurance- this primary insurance MUST be listed. We are unable to bill Medicaid/TennCare without first billing your primary insurance; in these cases, the insurance claim will be denied for incorrect information and this will result in delayed services for your child until billing is updated and approved. Thank you for your cooperation. **

Name of Primary Insurance Company/Carrier: _____

Member ID : _____ **Group ID:** _____

Name of Insured/Policyholder: _____ **Insured Member/Policyholder's Date of Birth:** _____

Patient's Relationship to the Insured: _____

Secondary Insurance Company/Carrier: _____

Member ID : _____ **Group ID:** _____

Name of Insured/Policyholder: _____ **Insured/Policyholder Date of Birth:** _____

Patient's Relationship to the Insured/Policyholder: _____

Is your child enrolled in Tennessee Early Intervention Services (TEIS)? : _____

If your child is participating with TEIS, please list their service coordinator's name below.: _____

Does your child currently have TennCare?: _____

Has your child ever had Tenncare in the past? : _____

By signing this form you grant Great Adventures Therapy permission to bill insurance for any visit where a service was rendered. You acknowledge that you will be responsible for any amount not covered by insurance (ex: co-pays, coinsurance, deductible amounts, non-covered charges, etc.) and that payment is due at the time the claim is finalized.

Parent/Guardian Signature: _____
Date: _____

CREDIT CARD INFORMATION & AUTHORIZATION FORM

This information will be saved to your account and used for billing purposes only. You will sign complete the information, upload photos of the front and back of your card, and sign below, allowing us to store your card on file and submit charges for visits as they are completed.

Card Type: _____

Name on Card: _____

Card Number: _____

Expiration Date (MM/DD/YYYY Format): _____

Three Digit Code On Back Of Card (CVV): _____

Zip Code (Must Match Billing Address For Card): _____

CREDIT CARD AUTHORIZATION

I authorize Great Adventures Therapy to charge my credit card through Fusion Web Clinic. I also agree that my credit card can be charged for any session that is not cancelled at least 24 hours prior to the scheduled session or for any appointment that is scheduled but not attended with no prior cancellation notice?(a "no show"?visit).

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Great Adventures Therapy in writing of any changes in my account information or termination of this authorization.

I understand that my payment is due at the time of service or upon claim processing and my card will be charged at the company scheduled billing interval. I understand that an invoice receipt will be made available to me within the Fusion Web Clinic Portal for my records.? I acknowledge that at times these payments may be delayed due to unforeseen issues with filing of insurance and that I am able to access my Explanation of Benefits from my insurance provider to coordinate Fusion billing, invoices, and dates of service.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

By your electronic signature of this form, you authorize charges to your credit card through via Fusion Web Clinic for services rendered or missed appointments per company policy. These charges will appear on your bank/credit card statement as Great Adventures Therapy. You have the right to request a paper copy of this document.

Parent/Guardian Signature: _____
Date: _____

RELEASE OF INFORMATION

This form is used to request information from additional medical providers as needed to gain information pertinent to your care by our therapy team. This form also allows us to send our records to those providers that have requested our information with your consent.

I authorize Great Adventures Therapy to send/receive any/all of the following:

Medical History/Evaluations/Medical Records
Mental Health Evaluations
Developmental and/or Social History
Educational Records
Progress Notes, Treatment Notes, and/or Summaries

This information may be requested from/sent to:

: _____

Please use the text box below to list names, location, phone, and fax numbers of providers selected above.:

By adding my signature below, I grant Great Adventures Therapy permission to request/release any and all medical records to the providers selected above.

Parent/Guardian Signature: _____
Date: _____

PRIVATE PAY FOR SERVICES AGREEMENT FORM

I understand that one of the below options applies to me/my child:

My insurance company will not be billed for any services rendered and that any payments made to Great Adventures Therapy will not be used towards meeting a deductible of any kind. I understand that I may request invoices as a receipt of payment and may request a specific itemized receipt (i.e. "superbill") to submit to my insurance company on my own behalf if I wish to seek reimbursement.

My child is receiving services through Tennessee Early Intervention (TEIS), but treatment for therapy through Great Adventures Therapy has not yet been added to the IFSP. I agree to pay for any remaining account balance after insurance is billed until treatment is added to our IFSP. Once treatment is added, all remaining account balances will be sent to TEIS.

Initials:: _____

By signing this document, I testify that I understand my therapist will be charging private pay rates for services provided to my child. These private pay rates were discussed with me verbally and I agree to pay the amount due for services. I also have a right to request a copy of a Good Faith Estimate for services my child receives while under the care of Great Adventures Therapy explaining these rates and acknowledge that payment is due at the time of service.

Parent/Guardian Signature: _____
Date: _____

Feeding/Orofacial Myofunctional Intake Form

Welcome!

Please fill out all paperwork at your earliest convenience. Your answers are saved as you go, so you don't need to finish it all in one sitting. However, please remember that the appointment made during your call with our staff is a HOLD, not a confirmed appointment slot.

Once our staff has received your completed paperwork, you will receive a call from our office to confirm your appointment time and you will then receive a text reminder 24 hours before your scheduled appointment.

Please let us know who is completing this form.

First and Last Name: _____ **Relationship to child.:** _____

Demographics

Please enter information pertaining to your child:

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Gender:** _____

Child lives with: (Select all that apply): _____

Address:

_____

_____

_____

_____

Mobile Phone: _____ **Other Phone:** _____

By checking this box, you agree to accept calls and/or SMS messages from Great Adventures Therapy.: _____

Email: _____

Preferred method of contact: _____

Referral Information

Who referred you to our practice?: _____

If "Another Provider" or "Other" was selected, please provide information here:: _____

Pediatrician/Primary Care Information

Please provide information pertaining to your child's primary care physician and other specialists that may be involved in your child's care.

Pediatrician Practice Location Name: _____ **Location Address:** _____

Practice Phone Number: _____ **Pediatrician Name:** _____

Family Information and History

Caregiver A

First Name: _____ **Last Name:** _____

Relationship to child: _____ **Mobile Phone:** _____

Email: _____ **Occupation:** _____

Address: _____

If selected "different address as child," please type the address below: _____

Caregiver B

First Name: _____ **Last Name:** _____

Relationship to child: _____ **Mobile Phone:** _____

Email: _____ **Occupation:** _____

Address: _____

If selected "different address as child," please type the address below: _____

List family members with related speech, feeding, cognitive, physical, hearing, and/or physical disabilities. If not applicable, please type "N/A.": _____

Primary language spoken at home: _____

If there are any other languages spoken within the home, please list them here.: _____

Medical History

Were there any complications during pregnancy with mother or child? (e.g., pre-eclampsia, gestational diabetes, delayed growth, etc). Please explain. If none, please put "N/A.":

Complete birth information below

Weeks Gestation at Birth (ex: 39 weeks and 1 day): **Weight at Birth:**

Were there any complications at birth? (e.g., need for oxygen, fetal distress, NICU Stay, emergency c-section, etc). If so, please explain. If none, please put "N/A.":

Hearing:: **Ear Infections (yearly):**

Does/Did your child have ear tubes?: **Vision::**

Last vision screen/test::

If your child takes any medications, please list the type in the chart below. If they do not take any medication, please mark "N/A" in the text box below.

Name of Medication	Reason	Frequency	Amount

Does your child have food allergies?:

Please list any information that may be helpful for us::

Describe any accidents, illness, surgeries, etc. since birth. If not applicable, please write, "N/A.":

Is your child currently receiving treatment or being followed by another medical professional? (Ex: ENT, GI, Cardiologist, Pulmonologist, etc.) If YES, please list the specialty, doctor name, name of the practice, and phone number of all professionals. If you do not have additional providers/specialists, you may type "N/A."

Doctor Name	Specialty	Name of Practice	Phone Number

Does your child have any medical diagnoses/conditions? (ex: Down Syndrome, Cerebral Palsy, Autism Spectrum Disorders, Prematurity, Heart condition, Respiratory condition, Cleft Lip/Palate, etc.) If YES, ple

Please provide information here.:

Please check all that apply to your child:

Behavior History

Check all that may apply to your child::

Developmental History

At what age did your child begin to:

Sit: **Walk:**

Run: _____ **Speak First Word:** _____

Start putting words together: _____ **Start using sentences:** _____

Has your child had any previous speech, language, or feeding therapy?: _____

Has your child been evaluated by other professionals (occupational therapist, physical therapist, etc.)?:

If YES, please provide details below.: _____

Educational History

School Information

School Name: _____ **Grade:** _____

Grades repeated, if any: _____ **Services presently offered or attending in school::** _____

Are there concerns about academic success? (ex: reading, writing, subject areas): _____ **Does your child like school?:** _____

How would you describe your child's behavior at school (shy, defiant, cooperative, etc.)?:

_____

_____

_____

_____

If your child is of school age, how would you describe his/her handwriting?: _____

Feeding History

Breastfeeding: Check all that apply: _____

Any other information or explanations for above.:

_____

_____

_____

_____

If bottles are/were used, please list all bottles or feeding systems attempted to date, and if any issues were present. If only breastfed, please type "N/A":

_____

_____

_____

_____

Any difficulty with bottle feeding?: _____

Please add any additional information regarding previous treatment with lactation consultant or other feeding professionals, concerns or issues, etc. If none, please type "N/A":

_____

_____

_____

_____

Eats cut up table foods: _____

Any additional information: _____

Drinks from an open cup: _____

Any additional information: _____

Independently uses spoon/fork: _____

Any additional information: _____

Weaned from breast: _____

Weaned from bottle?: _____

Weaned from sippy cup?: _____

Weaned from pacifier?: _____

Please list what type of pacifier was/is used and how often (ex: all day, only when napping, etc.): _____

Please check all that apply:: _____

Any Additional Information:

Where does your child sit during meals?:

Utensils Used:

Did your child eat their first birthday cake?:

Please elaborate feeding concerns here, letting us know any additional concerns or information that may be helpful for us to know during our evaluation and in treatment planning.:

Speech and Language Milestones

Do you have any present concerns regarding speech and language development? (babbling, first words, pairing words together, speech sounds, etc.):

If your child is being seen for an Orofacial Myofunctional Evaluation, please complete the questions below. If you are feeding only, please move to the next section: Social History.

Has your child received speech services before this evaluation?:

Have you ever been told your child has a tongue thrust (tongue coming between the teeth during speech or swallowing)?:

Has your child been treated by a dentist or orthodontist? (If YES, which one? Both?) If seeing an Orthodontist, please provide any relevant information in the space below:

Any Additional Information:

Do you have any specific questions regarding your child's speech/language that you want to mention before we meet? If so, please list here.:

Social History

When given a choice, does your child prefer to play alone or with others?:

Provide any helpful information here.:

Does your child participate in extracurricular activities with peers their age? (ex: sports, church, play groups, music time, etc.):

What are some of your child's favorite toys/interests?:

Is there anything else about either your child's history or current condition that you feel is important to mention?:

Parent/Guardian Signature:
Date:

Speech/Language Intake

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Please fill out all paperwork at your earliest convenience. Your answers are saved as you go, so you don't need to finish it all in one sitting. With this in mind, please remember that your appointment will not be confirmed until all paperwork is received by our office.

Please let us know who is completing this form.

MWI laOr sa Ol laLOt dN ____ : dkOlWr ! nWdayaRnWsN ____

hdt youOenW!

Please enter information pertaining to your child.

MWI laLOt dN ____ / Ol laLOt dN ____

hOldaypa WnN ____ Ddr sduN ____

RnWsa Wd! a WnNORndi aOklanOlaOeeKOvN ____

wssud! ! N

____

(ySWda) nyr daLf t SduN ____ AInduLf t SduN ____

. Cai ndi WoanWaSybROyf aOouddayaOi i delai OklaOr sgyuF(Fat d! ! Ood! apuyt aDudOlawsBdr Ifud! axnduOeC,N ____

: dpduuOkorpyut OlWr

I nyaudpduds aOyf ayayf uaeuOl IWdTN ____

qaEwr yIndue) uyBWduEayuEAInduEa? Ol a dkdi lds Reh dOl daeuyBWdaWpyut OlWr andudN ____

) ds WdluWOr g) uW OuCaROudarpyut OlWr

Please provide information pertaining to your child's primary care physician and other specialists that may be involved in your child's care.

) ds WdluWOr a) uOi lWda yi OlWr aLOt dN

____

/ yi OlWr awssud! ! N

____

) uOi lWda) nyr daLf t SduN ____) ds WdluWOr aLOt dN ____

MOt WCarpyut OlWr aOr sa' WlyuC

Caregiver A

MWI laLOt dNN ____ / Ol laLOt dN ____

: dkOlWr ! nWdayaRnWsN ____) nyr daLf t SduN ____

Ht OWN ____ Ai i f eOlWr N ____

wssud! ! N ____

qal dkdi lds aEsWpdudr laOssud! ! aOl ai nWsREaekdOl daCedandaOssud! ! aSdky? N ____

Caregiver B

MWI laLOt dN ____ / Ol laLOt dN ____

: dkOlWr ! nWdayaRnWsN ____) nyr daLf t SduN ____

Ht OWN ____ Ai i f eOlWr N ____

wssud! ! N ____

qal dkdi lds aEsWpdudr laOssud! ! aOl ai nWsREaekdOl daCedandaOssud! ! aSdky? N ____

Speech/Language Intake

/ WMapOt WCat dt SduI a? WhaudkOIds a eddi nRpdds WoRa yor WWkdRenC! WOHRndOuWoROr sgyuaenC! WOkasWOSWWW! ,apary laOeekWOSkdRekdOI dalCedaEL gv,N

) uW OLCaOr of Oodal ey dr aOIanyt dN

qpandudaOudaOr CayInduaOr of Ood! al ey dr a? WhWandanyt dRekdOI daWandt andudN

(ds WOkd' WIyuC

I dudaIndudaOr Caiyt ekWOIWyr ! asf uWoaeudor Or i Ca? Wh t yInduayuainWsTaGl,o,Reud-diKOt e! WORod! IOIWyr OkasWOSdld! RsdkOCdsaouy? InRdli v,a) kdOI dadbeKOW,apar yr dRekdOI daef laEL gvE,N

Complete birth information below

I dd ! aDd! IOIWyr aOIa WnaGbN89a? dd ! aOr safasOOvN

I dWnIaOIa WnN

I dudaIndudaOr Caiyt ekWOIWyr ! aOIaSWnTaGl,o,Rr ddsayuaybCodr RpdlOkasWud! ! RL cRUaFIOCRdt duodr i Cai -! di IWyr Rdli v,apdl yRekdOI dadbeKOW,apar yr dRekdOI daef laEL gv,EN

" dOuWoNN

HOuarpdi IWyr ! aGdOuKOvN

hyd! gh WaCyf uai nWsanOBdadOuaf Sd! TN

VWWyr N

/ OI laVWWyr axd! IgFi uddr N

If your child takes any medications, please list the type in the chart below. If they do not take any medication, please mark "N/A" in the text box below.

LOt daypa(ds WOIWyr	: dOIyr	Mudqf dr i C	wt yf r I

Rndi aOkanOIat OCaOeekCalyaCyf uai nWs,N

hyd! aCyf uai nWsanOBdayysaOkduoW! TN

hd! i uWdaOr CaOI i Wdr I! RWrd! ! Rf uoduW! Rdli ,a Wi daSWn,apar ylaOeekWOSkdRekdOI da? uWdREL gv,EN

" OI aCyf uai nWsanOsaOr CaeudBWyf ! a eddi nRKOr of OodRyuapdds WoaIndu.OeCTN

qpaYd! RekdOI dakdaf ! a r y? a? nOIaCedaypandu.OeCaOr saIndasf uOIWyr aypaudOIt dr I,N

" OI aCyf uai nWsaSddr adBOKf OIdsaSCayInduaeuypd! ! Wyr OkaGyi i f eOIWyr OkanduOeWRenC! WOkandu.OeWRdli ,vTN

Is your child currently receiving treatment or being followed by another medical professional? (Ex: ENT, GI, Cardiologist, Pulmonologist, etc.)
If YES, please list the specialty, doctor name, name of the practice, and phone number of all professionals. If you do not have additional providers/specialists, you may type "N/A."

hyi IyuLOt d	Fedi WOHC	LOt daypa) uOIWd	) nyrdaLf t Sdu

hyd! aCyf uai nWsanOBdaOr Cat ds WOkasWOr y! d! giyr sWWyr ! TaGbNhy? r aFCr suyt dRRdudSuOk) OKCRwf IWt aFedi luf t ahWyusduIR) udt OIf uWCR' dOuIaiyr sWWyr Ra d! eWOIyuCaiyr sWWyr RRkdpIa Wg) OKOIdRdli ,vapaYHF Rekd

hdBdkyet dr IOkd' WIyuC

At what age did your child begin to:

FWN ____________________ I CkN ____________________

: f r N ____________________ FedO aMW la yusN ____________________

FlOUa) f llWoa yus! axyodlnduN ____________________ FlOUaU! WoaFdr ldr i d! N ____________________

Hsf i OlWr Oka' WlyuC

School Information

Fi nyykL Ot dN ____________________ DuOsdN ____________________

DuOsd! audedOldsPWOr C,N ____________________ FduBWd! aeud! dr lkCaypdudsayuaOlldr sWoaWa i nyykN ____________________

hyd! aCyf uai nWsaWda i nyykTN ____________________ wudandudai yr i dur ! aOSyf laOi Osdt Wa f i i d! ! TaGlbNaudOsWoP? uWWoPa f Sjdi laOudOlvN ____________________

" y? a? yf ksaCyf asd! i uWdaCyf uai nWs'! aSdnOBWyuaOla i nyykaGnCPsdpWr lPa yyeduOlWdPdli ,vTN ____________________

qaCyf uai nWsaWaypa i nyykaOodPny? a? yf ksaCyf asd! i uWdanWgnduanOr s? uWWoTN ____________________

Feddi ng Or of Ooda' WlyuC

hyd! aCyf uai nWsasdt yr ! luOldapuf ! luOlWr a? ndr andg nda Wa ryla f r sdul lyysTN ____________________

hyd! aCyf uai nWsadr oOodaWadCda yr lOi lasf uWoa yt t f r WOlWr TN ____________________

Fyi WOka' WlyuC

I ndr aoWdr aOa nyWdPsyd! aCyf uai nWsaeudpdualyaeKCCaOkyr dayua? WnaylnduI TN ____________________

) uyBWdaOr Candkepf kaWpyut OlWr andud,N ____________________

hyd! aCyf uai nWsaeOuIWWOldaWadbluOi f uuWf KOuaOi lWWW! a? Wnaeddul andWOodTaGlbNa eyul ! Pa nf uinPekOCaouyf e! Pat f ! WaW dPdli ,vN

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I nOlaOudayt daypaCyf uai nWs'! apOByuWdayC! gWldud! l! TN

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d andudaOr CnWoadK daOSyf laWnduaCyf uai nWs'! anWyuCayuai f uudr la yr sWr anOlaCyf apddkaWaW eyulOr lalyat dr lWr TN

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" Ol aCyf uai nWsaudi dWdsa eddi na duBWd! aSdpyudanWadBOf OlWr TN ____________________

hyaCyf anOBdaOr Ca edi WWaqf d! lWr ! audoOusWoaCyf uai nWs'! a eddi ngOr of OodanOlaCyf a? Or lalyat dr lWr aSdpyuda? dat ddlTapaly PekdOl daWandud,N

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) Oudr lgDf OusWr aFWr Olf udN ____________________
hOldN ____________________

ACKNOWLEDGMENT OF PRACTICE FORMS

I hereby acknowledge and agree that I had read all of the forms and documents provided to me in connection with evaluation and treatment provided by Great Adventures Therapy.

I understand the meaning and intent of the provided forms and agree to all content included.

I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by Great Adventures Therapy.

Parent/Guardian Signature: _____

Date: _____