Brain and Body Therapy
Creating Change

New Patient Information Packet – Pediatric

Date: _____

Child's Name: _____ Sex: □ Male □ Female
First M.I Last
Pronouns: _____

Nickname/Preferred Name: _____ DOB: _____ Age: _____
D / M / Y

Address: _____
Street City State Zip

Parent/Legal Guardian Responsible for Payment:

_____ Pronouns: _____
First M.I Last

Relation to Patient: _____

Address: _____
Street City State Zip

Email: _____ Phone:_____ □ Work □ Cell □ Home

Appointment Reminders: □ Text □ Email

Other Guardian (if applicable):

_____ Pronouns: _____
First M.I Last

Relation to Patient: _____

Address: _____
Street City State Zip

Email: _____ Phone:_____ □ Work □ Cell □ Home

Emergency Contact:_____ Pronouns: _____
First M.I Last

Relation to Patient:_____ Phone:_____

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Medical History

Please List Any Known Diagnoses Date of Diagnosis

_____

_____

_____

Current Medications Treating for.. Dosage AM/PM

_____

_____

_____

_____

_____

Within the last 2 years has your child experienced any events which required medical attention or hospitalizations? □ No □ Yes

If yes, please explain:

_____

_____

_____

_____

_____

Any other information we should know:

_____

_____

_____

_____

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Therapy Focus

Is your child currently receiving services outside of Brain and Body Therapy: (Check all that apply)

□ Talk Therapy □ Art Therapy □ Biofeedback □ ABA □ Music Therapy

□ Speech Therapy (□ outpatient □ in school) □ Occupational Therapy (□ outpatient □ in school)

□ Physical Therapy (□ outpatient □ in school) □ Other: _____

Does your child experience difficulties in the following areas: (check all that apply)

□ Touch / Tactile □ Noise / Sound □ Attention □ Vestibular / Movement

□ Vision □ Body Awareness / Proprioception □ Emotional Regulation

□ Transitioning between activities □ Academics □ Body pain (stomach, head)

What are your primary goals for therapy?

_____

_____

_____

_____

BRAIN AND BODY THERAPY
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HIPAA Privacy Authorization Form

Effect Date (today's date): _____

Authorization for Use or Discussion of Protected Health Information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization. I authorize Brain and Body Therapy (healthcare provider) to use and disclose the protected health information described below to any medical entities as needed.
2. Effective Period. This authorization covers all past, present, and future period of health care.
3. Extent of Authorization. I authorize the release of my complete health record.
4. Use. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation or other purposes as I may direct.
5. Termination. This authorization shall be in force and effect until 2 years from effect date at which time this authorization form expires.
6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already active in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim
7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. Disclosure. I understand that Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name: _____

Signature (or Personal Representative): _____

Date: _____

BRAIN AND BODY THERAPY
CREATING CHANGE

Credit Card Authorization Form

Please initial next to **one** statement:

_____ I authorize Brain and Body Therapy to keep by card on file. Please fill out the forum below.

_____ At this time, I do not authorize Brain and Body Therapy to keep by card on file.

If you agree please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: □ Master Card □ VISA □ Discover □ AMEX □ Other:
Cardholder Name (as shown on card):
Last 4 Digits on Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file future transactions on my account.

_____ _____

Customer Signature Date

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Consent to Treat

By initialing next to each statement you agree to the following:

_____ I have provided Brain and Body Therapy with my child's full medical history. I will inform my therapist of any medical changes.

_____ I acknowledge that massage and bodywork by Brain and Body Therapy should not be construed as a subsidize for medical examination, diagnosis, or treatment.

_____ I acknowledge that Brain and Body Therapy will bring in equipment into my household as part of the treatment session which includes but is not limited to: massage table, linens, bolsters, Bal-A-Vis-X (BAVX) equipment. I am responsible for any damage done to equipment by individuals outside of the scheduled client (pets, other children, etc.).

_____ I will provide payment at time of service.

_____ In the event my child needs medical assistance (Heimlich maneuver, CPR, etc.) or requires medical equipment (inhaler, EpiPen, etc.) I will provide item whereabouts and demonstrate proper item usage. I give permission to the treating therapist to utilize his/her professional judgement to intervene in event of medical necessity.

_____ I hereby waive and release the massage therapist and associated business from any and all rights and claim for damages that may occur during or after the treatment session.

I _____ am the parent or legal guardian for the patient listed on this form and on the patient's behalf, hereby request and consent to the child listed on this form, to be treated.

Child's Name: _____ Date: _____

Parent or Guardian name: _____

Signature: _____