Client Personal Data Sheet

Keiki Therapy

Child's Last Name: **First:** **Middle:**

Date of Birth: Today's Date:

Father's Name Mother's Name

Mailing Address City

Zip Home Phone Mom Cell Phone

E-mail: *Circle Best #* Cell Phone

Father's Employer Mother's Employer

How did you hear about Keiki Therapy? Who referred you? Please circle one below

Doctor - Flyer/Pamphlet - Internet Search - Facebook - Daycare - Other Professional - Friend

If Other Professional OR Friend what is their name?

Medical Information

If your child has private insurance please list the **card holders full name and date of birth**

Health Insurance Provider and Number:

Health Insurance Provider's Date of Birth

Physician / Clinic

Please provide copies or allow us to make a copy of all insurance and/or Medicaid Cards

Medicaid Number

Describe any Pregnancy Complications:

Was your child: Full Term Premature Birth Weight If Premature-How many weeks

Has your child ever been hospitalized? If Yes Explain

Has your child ever had a seizure? How often? If yes date of last seizure.

Has your child had tubes in ears? How many times and what age?

Medications currently taking Wear Glasses?

Disease History: Please circle any below that apply and write any that are not listed

Measles TB Mumps Seizures Other

Check One: ☐ **ALLOW** Photos of my child for Evaluation-Treatment - Publicity

☐ **DO NOT Allow** Photos of my child for Evaluation-Treatment - Publicity

Has your child seen any of the following specialists? If any where and at what age/s

Audiologist Occupational Therapist Physical Therapist Speech Therapist Neurologist

Allergies

Food Hypersensitivities

School or Daycare child attends: If daycare what times and days:

What are your concerns for your child? What do you want us to work on? Please be specific and use back of paper if needed.

Confidential

Emergency Contact Information

Name of Person to contact if Parents cannot be reached _____

Relationship _____ Phone _____

Address _____ City _____

Is this person authorized to take your child from the clinic? _____

List all other adults who are authorized to take your child from the clinic

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Keiki Therapy will bill your insurance for services unless you request otherwise. If insurance does not cover services you will be responsible for payment. If you have questions or concerns about the cost of therapy please ask.

Emergency Medical Treatment Release

I, _____ Father, Mother, Guardian of _____ do hereby give my consent to the Director or authorized person at Keiki Therapy LLC clinic, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of emergency when the parents or guardians cannot be reached.

Due to liability and insurance issues it is Keiki Therapy's policy that children who do not receive treatment at our clinic cannot be allowed to play in the therapy treatment area. Also, unless your child is receiving therapy they cannot play in the therapy treatment area. Please wait in the waiting room for your therapist to get your child for therapy. If your child who receives treatment has siblings, friends or other family that come to the clinic during your child's treatment, please do not allow them to play in the therapy treatment area. Again, this is for insurance and liability purposes. If you chose to be in the therapy treatment area during your child's treatment please be respectful and quite due to other children/adults receiving treatment.

Please Note: Your health information will be kept confidential. Any information that we collect will be kept confidential.
Keiki Therapy may occassionally send you a text or email message about scheduling and information

If your child is covered by private insurance, your signature below assigns benefits/payment for therapy to Keiki Therapy LLC from your child's insurance. If you have private insurance It is possible that you may have a deductable or a co-pay for each therapy evaluation or treatment session. Charges not covered by private insurance are your responsibility. Your signature below indicates that you both understand and agree to these terms.

It is important that your child be seen by their primary care physician at least once a year. Doctor's will usually not prescribe therapy treatment or evaluations unless they see them in the doctor's clinic at least once a year. If you have switched doctors or clinics you will need to make an appointment with them before they will prescribe therapy treatment or an evaluation.

Please keep us informed of changes to your child's insurance or Medicaid.

By signing below you understand and agree to all of the above policies and give Keiki Therapy permission to evaluate and/or treat your child.

Child's Name _____

_____

↑ **Printed Name of Parent / Legal Guardian** ↑ **Signature** **Date**