



The Lotus Tree

The Lotus Tree
Sensory Integration Center
3169 South Bown Way
Boise, Idaho 83706
p) 208-433-9152
f) 208-344-4752
www.thelotustreesi.com

Patient Information (Child)

Date: ___/___/___

Patient's Full Name (please print) _____ Date of Birth ___/___/___ F ___ M ___

Parent/Guardian 1 _____ Cell _____ Work _____

Parent/Guardian 2 _____ Cell _____ Work _____

Street address _____ Home phone _____

City _____ State _____ Zip _____ Email _____

Primary Care Physician _____ Phone _____

Diagnosis(es) with dates _____

Do you agree with diagnosis(es)? _____

Referred by _____ Service Coordinator (if applicable) _____

What therapies has patient received within the current calendar year? Please include therapist's name, location, and (for repeating appointments) days and times: (OT, PT, SLP, IBI, counseling, vision, music, equine, etc)

Insurance (Please also present your member card to our staff for copying. Thank you.)

Medicaid # _____

Insurance Provider _____

Subscriber # _____ Group # _____

Subscriber Name _____ Relationship to Patient _____

Date of Birth ___/___/___ Place of Employment _____

*Address _____ City _____ State _____ Zip _____

**(If different than patient's address)*

School Information (if applicable)

Name of school: _____ Teacher's name: _____

Grade: _____ Has child ever repeated a grade? ___ yes ___no

Strengths and/or best subjects: _____

Difficulty with any subjects: _____

Receiving help with any subjects: _____

Comments/concerns about school: _____



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Family Information

Primary language in home: _____ Primary language of child: _____

Other language spoken in home: _____ Child speak language? Yes ___ No ___

Any cultural influences in the home or family _____

Child lives with: ___Both birth parents ___Foster parents ___Mother OR ___Father
___ Adoptive parents ___ Parent and step-parent ___ Other: _____

Other children in family:

Name	Age	M/F	Grade	Developmental Concerns
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Birth History

Explain anything unusual about the pregnancy or birth? _____

Mother's age at birth: _____ years old

Birth weight: _____

Did patient have the following?

___premature birth, how many weeks was pregnancy? _____

___NICU stay, how long? _____

___colic

___poor suck, swallow, breathe

___infant sensitivities, explain _____

Developmental History

Please note the approximate age your child achieved the following developmental milestones:

rolled _____ crawled _____ babbled _____ put two words together _____

sat up alone _____ walked _____ said first words _____ toilet trained _____



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Current Health

Current Medications: _____

Alternative, homeopathic, herbal therapies being used: _____

Describe your child's health concerns: _____

Describe behavioral concerns: _____

Describe your child's strengths: _____

What areas do you hope your child will improve during therapy? _____

Are there any nutritional or feeding problems? _____

Describe any sensitivities (noise, taste, etc.): _____

Allergies to medications or foods: _____

Check all that apply:

- | | | | |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Oral/speech problems | <input type="checkbox"/> Swallowing restrictions |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug/alcohol exposure | <input type="checkbox"/> Feeding difficulties |
| <input type="checkbox"/> RSV | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Reflux | <input type="checkbox"/> Missed milestones | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Motor skill issues | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ear infections/tubes | <input type="checkbox"/> Sleeping difficulties |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Allergies | <input type="checkbox"/> Thumb/finger sucking | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Irritable bowels | <input type="checkbox"/> Other | | |

Please give more details about all areas checked: _____

The Lotus Tree Sensory Integration Center Policies and Procedures

Please initial each line and sign below. Thank you.

_____ I request and consent to receive treatment for _____ at The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center.

_____ Information provided on the Patient Information form is correct to the best of my knowledge. I grant The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center the right to release my medical information and treatment history to third party payers and/or other healthcare professionals as needed.

_____ I and/or the responsible party agree to assign The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

_____ I understand that if my insurance provider requires a referral for treatment, it is my responsibility to obtain the referral prior to my first appointment. I also understand that if I do not have prior written referral from my physician, I am fully financially responsible for any unpaid balances of current or past appointments. I accept responsibility for keeping my referral current and renewing it when necessary. Further, I agree that I am responsible for payment for any visits beyond that of my insurance coverage.

_____ I authorize The Lotus Tree to submit claims on my behalf to my health insurance agency. I authorize my insurance company to make payments directly to The Lotus Tree for services rendered.

_____ I understand that my bill is to be paid within 30 days of the invoice date unless otherwise arranged with The Lotus Tree billing department. I understand that after 30 days a late fee of 1.5% monthly will be added to my account. I understand that there is a \$35.00 fee for each check returned unpaid. In the event of default of payment I agree to pay fees accrued on my balance due, as well as collection costs and/or legal fees incurred for collection of my account.

_____ The Lotus Tree requires 24 hours notice in the event of a cancellation. The Lotus Tree recognizes that in an unforeseen circumstance an absence without notification can occur. However if a second absence should occur, a \$25.00 fee may be charged to your account. A third absence of appointment will result in possible termination of services at The Lotus Tree.

Release of Liability

_____ I am fully aware of the risk of injury and/or death, as well as other damages and losses associated with the participation in activities and programs at The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center and release The Lotus Tree from associated liability. I hereby waive and release the owner, staff members, and/or therapists employed by The Lotus Tree of liability for personal injury or accident of any sort suffered by the participant named, by reason of participation in classes, treatment or any other various activities at The Lotus Tree. I hereby agree to release The Lotus Tree of any liability for litigation expenses, attorney fees or loss liability that may occur as the result of any such claim.

_____ I understand the nature of these activities and understand the minor's capabilities, health level and physical condition, and believe the minor to be qualified to participate and/or receive treatment at The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center.

_____ In the event myself or my child requires emergency care, I hereby authorize any associate of The Lotus Tree Sensory Integration Center/The Lotus Tree Speech and Language Center to obtain medical care and treatment without further authorization.

Name (Please Print) _____ Signature _____ Date _____

Patient's name (Please Print) _____ Relationship to Patient _____

In the event of an emergency, please contact: _____ Phone: _____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization that the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient (If patient not signing): _____

Signature: _____ Date: _____

Office Use:

Diagnosis: _____ / _____

Plan Effective Date: ___/___/___ thru ___/___/___ Co-pay: \$ _____

Deductible: Individual \$ _____ Family \$ _____ Met yet this year? Yes No

% of coverage after deductible is met _____ Amount met so far : _____

Maximum benefit allowance for: ___ OT ___ PT ___ ST

Number of visits allotted per year: _____ AND/OR Max amount for therapy per year: \$ _____