ZELEXA

Face Sheet

Child's Information

Child's Name _____ Date of Birth _____

Child's Social Security Number: _____

Diagnosis: Rx Date of diagnosis: _____

Parents Information

Mother's Name: M name Email: _____

Home: _____ Cell: _____ Work: _____

Father's Name: F name Email: _____

Home: _____ Cell: _____ Work: _____

Address: _____

Emergency Contacts

Primary Contact

Name: _____ Relationship: _____

Address: _____

Home#: _____ Cell: _____ Work: _____

Secondary Contact

Name: _____ Relationship: _____

Address: _____

Home#: _____ Cell: _____ Work: _____

Insurance-Employer

Primary Insurance

Policyholder's Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____ Phone:_____

Secondary Insurance

Policyholder's Employer: _____

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Employer’s Address: _____

City: _____ State: _____ Zip Code: _____ Phone:_____

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Coordination of Service

- -

Physician - Primary Care

Name: ____ Phone:__________________

Address: ____

I authorize Zelexa and the listed primary care physician to discuss and exchange information/records regarding my child.

____ __________________________

Parent/Guardian Signature Date

Information exchanged with Primary Care Physician:

Date Method Information Communicated

____

____

____

Other Service Provider

Name: ____ Phone:__________________

Address: ____

I authorize Zelexa and the listed primary care physician to discuss and exchange information/records regarding my child.

____ __________________________

Parent/Guardian Signature Date

Information exchanged with Primary Care Physician:

Date Method Information Communicated

____

____

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Developmental History

Birth History

Describe the pregnancy including any complications

Development

Describe the child's development

Estimate when the child first:

Smiled	_____	Sat up on own	_____	Said 1st word	_____
Crawled	_____	Stood	_____	Fed self	_____
Walked	_____	Ran	_____	Toilet trained	_____

Were there any illnesses during the first 2 years?

Behavioral Development

Describe your current behavioral concern: _____

Does your child have tantrums? □ No □ Yes

If yes, please describe how these developed and changed overtime:

What discipline techniques have been used?

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Developmental History (cont)

Social History

Does your child make friends easily? □ No □ Yes

Describe your current social concerns:

How does your child get along with others?

Have there been any losses, changes or transitions I your child's life?

Does the family have any spiritual, cultural, or religious beliefs that influence the child?

What play activities does your child enjoy?

Communication History

How does your child communicate his wants/needs?

How does your child communicate urination and defecation needs?

What is your current communication concern?

Family History

Please list all members of the household, ages, and their relationship to the child:

Describe any current concerns about the home & community:

Are there any traditions/events that are important to your child?

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Developmental History (cont)

Educational History

What educational settings has your child participated in?

How does your child learn best (what is their learning style)?

What are your concerns about school?

Questionnaire

Attends to others	□ No	□ Yes
Listens to peers	□ No	□ Yes
Initiates interaction with peers	□ No	□ Yes
Initiates conversation with peers	□ No	□ Yes
Maintains interaction with peers	□ No	□ Yes
Participates in a group learning environment	□ No	□ Yes
Organized	□ No	□ Yes
Able to problem solve	□ No	□ Yes
Understands feeling of others	□ No	□ Yes
Adapts to change	□ No	□ Yes
Affectionate towards others	□ No	□ Yes
Understands rules & consequences	□ No	□ Yes

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Developmental History (cont)

Other

How does your child prefer to spend his/her time?

What are your favorite things about your child?

Is there any additional information you feel would be helpful to the treatment of your child?

Do you have any special requests?

What else do you want us to know about your child in regards to ABA Therapy and/or Speech Therapy?

What goals for your child are most important to you?

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Medical Information

- -

Medical History

Medical Allergies □ No □ Yes, please list ______________________________

Food Allergies □ No □ Yes, please list ______________________________

History of Seizures □ No □ Yes, Frequency & intensity ______________________________

Special Diet □ No □ Yes, please list ______________________________

____

History of mental illness in your family □ No □ Yes, please describe ______________________

____

Currently being treated for medical condition(s)? □ No □ Yes, please describe __________________

____

Current Medications

Current Medications For what condition Dosage Frequency Comments

____

____

____

Are there any medications that will be delivered at the Treatment Center?

□ No □ Yes, please complete Medicine Information Form below

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Educational History

- -

Child's Information

Child's Address:

Sex: □ Male □ Female Child's Social Security Number: _____

Parents Information

Mother's Name: _____ Email: _____

Home: _____ Cell: _____ Work: _____

Father's Name: _____ Email: _____

Home: _____ Cell: _____ Work: _____

Educational Information (Please list therapies received and schools attended)

Date Started Date Ended Provider Services/Placement Reasons for discontinuing

_____

_____

_____

If your child is in school, please answer the following:

Name of school and grade in school: _____

_____

Teacher's name: _____

What are your child's strengths and weaknesses academically?

_____

_____

What are your child's strengths and weaknesses in regards to peer interactions?

_____

_____

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Behavioral Challenges

Date Began Behavior Describe how you handle the Behavior:

_____

_____

_____

Current Daily Schedule

Describe

_____

_____

_____

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Speech Therapy

(only those interested in speech therapy services need to fill out this section)

- -

Speech-Language Hearing

Please describe any difficulties your child has in the area of speech/language.

_____

_____

_____

Has your child ever had a speech/language evaluation? □ Yes □ No

If so, please provide us with a copy of the evaluation report and most recent progress report, if applicable. If your child has been evaluated by a public school, please provide a copy of the Full Individual Evaluation and the current IEP.

Has he/she ever had a hearing evaluation? □ Yes □ No

If yes, where and when? _____

What were you told? _____

_____

_____

_____

Has your child received any other evaluation or therapy (physical therapy, occupational therapy, vision, etc.)? □ Yes □ No

If yes, please describe. _____

_____

_____

_____

Is there a language other than English spoken in the home? □ Yes □ No

If yes, which one? _____

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Financial Liability

Most commercial insurance plans will only pay for testing and treatment services that they determine to be “reasonable and customary.” Often such determination is made after services have already been provided. If an insurance company or a governmental program deems that the service was not “reasonable and customary,” they will deny payment for these services or procedures.

Zelexa will check benefits and pre-certify your services if necessary with your insurance company; however, a quote of benefits is not a guarantee of payment from your insurance company. This office is not responsible for your share of the cost of service nor are we responsible for managing your individual benefits. Your contract with your insurance company defines the guidelines you must follow; we have no access to this contract, therefore, it is your responsibility to notify Zelexa of any changes to your policy/benefits that may affect billing. Additionally, it is your responsibility to monitor, manage, and notify Zelexa of any limitations (such as number of visits) that affect billing and or treatment. Use of our billing service does not remove your responsibility for any or all charges incurred in treatment. If you have questions or concerns it is your responsibility to verify with your insurance company.

We are committed to serving you in a professional and fiscally responsible manner, but certain situations may arise in which payment is denied to our facility. In that circumstance, the patient or his/her guardian will be liable for any and all charges incurred.

Please read and sign below. If you have any questions, please direct them to our Administrative Department.

I have read and understand the above statements. I acknowledge that I have been informed that payment by my insurance carrier could be denied or discontinued for a variety of reasons. If my insurance carrier denies payment, I agree to be personally and fully responsible for payment.

Printed Name

Parent/Guardian Signature Date

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Insurance Billing/Reimbursement

Zelexa is “in network” with some insurance companies. If we are considered “in network” and have a contractual agreement with your particular insurance company, we will be happy to courtesy bill your insurance company for services provided to your insurance company. If the insurance company denies payment, you are responsible for payment (see financial liability agreement). In order to bill your insurance company we will need a copy of your insurance card, a copy of your child’s diagnosis from a physician and/ or school district, and a prescription for ABA services from your physician.

If we are unable to courtesy bill your insurance company, you personally may be able to submit receipts directly to your insurance company for services rendered to obtain reimbursement. The invoice that you receive at the beginning of each month will not be sufficient for your insurance. We will be happy to provide you with receipts after the services are delivered. The receipt will need to contain dates of services therefore services will need to be delivered first. The insurance company will need a diagnosis code on the receipt so we will need a copy of your child’s diagnosis in order to put this on the receipts.

Assignment of Benefits

Patient (Client) Name:

Policy Holder Name:

Ins Company:

I hereby authorize payment of benefits, otherwise payable to me, for services rendered by the provider, Zelexa, and/or as indicated on the enclosed bill or claim. I understand that I am financially responsible to the provider for all charges not covered or not paid by my health care benefit plan within sixty (60) days after billing. I also understand that the provider may require that I pay the estimated non- covered charges before the completion of an insurance bill or claim. This Assignment of Benefits is valid and in force until I cancel it in writing.

_____ _____

Policy Holder Signature Date

_____ _____

Parent/Guardian Signature Date

ZELEXA

Notice of Privacy Practice

THIS NOTICE DESCRIVES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.

PLEASE REVIEW CAREFULLY.

Medical Information:

Zelexa understands that your treatment information is personal to you, that is why we are committed to protecting your information. A record is created for you when you first come in. This record has information of the services that your child receives. You have the right to limit the disclosure to insure proper treatment and payment.

Disclosures of Medical information:

The following are descriptions of different ways we may disclose your information. Not every disclosure is listed; however we are permitted to use this information that may fall in one of these categories.

Coordination of Services: We may disclose your child's information to another service provider if you have signed a release of records consent.

Emergency Situations: We may disclose basic information about your child to provide emergency medical treatment in case of an emergency. This could be doctors, nurses or other emergency staff.

Payment: We may disclose information about your child to an insurance company so we may bill and collect on the services that your child received.

Individuals Involved in Your Child's Care: We may release treatment information about your child to family members or family friends who are involved in your child's treatment.

As Required by Law: We will disclose medical information about your child when required to do so by federal, state, and local law.

Health care Audits: We may disclose this information to an audit agency for activities authorized by the law. These audits may include investigation, inspections, and credentialing.

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Notice of Privacy Practice (cont)

Your Rights:

The Right to Records: You have a right to your child's treatment information. You can do this by calling Zelexa's Administrative Department. An appointment will be set for you to come in and review them. You may also have copies your records, although we will need a 30 day notice to collect them for you.

Restriction Right: You have the right to restrict the disclosure of your child's treatment information. You also have the right to limit the information we disclose about your child to someone involved in your child's care, such as family.

To request restrictions, you must make the request in writing to outline what information you want limited and whom you want the information limits to apply towards (Please see Medical Release Form).

Right to Request Confidential Communication: You have the right to request that we communicate your child's information to you in a certain way or at a certain location. For example, you can ask us to only contact you at work.

To request confidential communications, the request must be in writing and include how we may get in touch with you. We will try to accommodate all reasonable requests.

Right to Have a Copy of the Privacy Notice: You have the right to have a copy of this notice. You may ask us for this copy at any time.

Changes to this Notice: We reserve the right to change this notice. We reserve the right to revise without prior notice and you will receive a copy.

Complaints: If you believe that your privacy has been violated, you may file a complaint with our office.

Other: If you provide us with permission to use or disclose information about your child you may revoke it at any time. This must be in writing with your written authorization. You understand that we are unable to take back any disclosures that were already made with your permission.

_____ _____

Parent/Guardian Signature Date