



Buster's Kids Clinic
 120 E Hospital Drive
 Angleton, TX 77515
 Ph: (979) 849-2447
 Fx: (979) 848-8337

Child's Name:		DOB:	Age:
Parent/Guardian name 1:			
Parent/Guardian name 2:			
Home address:			
City:		State:	Zip:
Primary phone:		Cell/Home/Work?	
Secondary phone:		Cell/Home/Work?	
Email:			
Emergency Contact Name:			
Emergency Contact Phone Number:			
Emergency Contact relationship:			
Sibling's names and ages:			
Who else lives in the home:			
Any special living circumstances (for example, adoptions, shared custody, etc.):			
Languages spoken at home:			
Primary Insurance:		Secondary Insurance:	
Id#:	Group#:	Id#:	Group#:
Insurance phone #:		Insurance Phone #:	
Policy Holder First Name:		Policy Holder First Name:	
Last Name:		Last Name:	
DOB:		DOB:	
Address:		Address:	
Phone #:		Phone #:	

Referring physician:	Phone #:
Primary pediatrician:	Phone #:
How did you hear about our clinic?	
What concerns do you have about your child's development?	
Has your child received OT/PT/ST in the past?	

Child's Medical History

Diagnosis (if applicable):	
Was your baby born full term? If no, was his/her gestational age?	
Any prenatal or birth complications?	
Does your child have a history of the following: (check all that apply)	
Ear infections	Tubes in ears
Tonsillitis	Frequent colds
Respiratory infections	Reflux
Seizures	Vision/hearing problems
Please give a brief history of the above concerns:	
Please describe any other medical and surgical history:	
Please list any medications that your child takes regularly or for emergency use:	
Please list any drug, food or environmental allergies that your child has :	

Child's Developmental History (please write age each occurred)

Please write age each milestone occurred. If your child has not reached this milestone, please put N/A.		
Rolled over:	Babbled:	Sat up without help:
Spoke 1 st word:	Crawled:	Walked:
Put words together:	Potty trained:	Dressed self:
Fed self:	Drank from an open cup:	
Was there a period when your child quit talking? If so, please describe.		
Was your child breast of bottle fed? Any complications?		
Does your child have an exaggerated gag reflex? If so, please explain.		

Does your child have problems eating or drinking? If so, please explain.
If your child a picky eater? If so, please explain.
Has your child ever had a swallow study? If so, please explain.

Child's Behavior

Please describe any general behavior concerns that you have for your child at home, school/daycare and in the community.
Does your child have difficulty sitting still/paying attention?
Does your child have difficulty concentrating? In what situations?
Has your child ever been referred to a behavioral specialist? If so, please describe.
Please describe your child's strengths and special interests:

Child's Daily Schedule

How well does your child sleep? Does he/she sleep through the night? Fall asleep easily? Please explain.
If your child is not in school yet, where does he/she stay during the day?

Child's School Information

School:	Grade:
Is your child enrolled in special education? Please explain.	

Parent Goals and Expectations:

If your child requires therapy, what are your personal goals/expectations? What would you like your child to learn? Please describe and add any other helpful information.

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May we leave messages regarding your child's appointments at your home/cell?

YES NO initial _____

May we leave messages regarding your child's appointments at your work?

YES NO initial _____

May we send appointment reminders via text message to your cell?

YES NO initial _____

Primary # _____ Secondary # _____

Although a parent or guardian is required to be on site for all evaluations, we understand that there may be an occasion where someone other than the parent or guardian may bring the client in for his/her therapy services. In this case, it is important that our therapists be able to share important information about their therapy services with this person. Please indicate below who, besides parent/guardian, may bring your child in for therapy. *Must be 18 years of age or older.*

Name:	Relationship:

With my signature below, I release employees of BACH Buster's Kids to discuss my child's medical information, condition, and progress with the individuals named above.

Signature of Parent/Guardian _____ Date _____

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Emergency Procedure Protocol

All BACH therapists are required to have Pediatric CPR/First aid certifications. Minor injuries will be assessed by therapist, parent/caregiver will be notified immediately, and an incident report will be filed.

Medical Emergencies: All BACH staff has been instructed to call 911 in the case of any emergency condition; this includes but is not limited to shortness of breath, unconscious episode, a seizure lasting more than 5 minutes, severe pain, head injuries requiring medical intervention or suspected broken bones. *In the case of a medical emergency as stated above, BACH Buster's Kids will not assume responsibility for payment of doctor, hospital, ambulance, or any other medical expense.*

Seizure precautions: If a child has a seizure while at Buster's Kids, therapists are trained to turn patient on his or her side, cushion head, monitor mouth/tongue, loosen tight clothing and time the seizure. 911 will be called if a seizure lasts more than 5 minutes, if a child is slow to recover, or if the child has difficulty breathing. Parent/guardian is to be notified immediately.

G-tube care: If a patient's g-tube dislodges, the therapist will stop treatment and notify parent/guardian immediately. Clean dressing and tape is available for this occasion. A new g-tube should be placed within 1-4 hours by parent/guardian or the child's doctor.

Tracheotomy tube care: If a tracheotomy tube dislodges, therapists will stop treatment immediately and notify the patient's caregiver. If a patient's tracheostomy tube dislodges and parent/guardian is not present, 911 will be called. Therapists are not trained on tracheostomy care. **For this reason, children who have tracheostomy tubes are required to have a parent/guardian or nurse in the facility at all times with no exceptions.**

If a child requires emergency medication, has a tracheostomy tube, or has a vagal nerve stimulator, a parent/guardian or nurse is required to remain in the facility at all times with no exceptions.

I, _____, parent/guardian of _____, have read the above stated emergency procedure protocol. I understand and agree to the above policy for my child. I authorize BACH Buster's Kids staff to call 911 in the case of emergency and will not hold BACH responsible for payment of doctor, hospital, ambulance or any other medical expense.

Printed Name of parent/guardian:

Signature: _____

Date _____

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Attendance Policy

It is the intention of BACH Buster's Kids to ensure that each child's therapy program is productive, providing the best opportunity for the child to meet the stated goals and develop to their full potential. Please assist us in providing these services by notifying us in advance of cancellation or schedule changes. Cancellations must be made by calling our office at 979-849-2447.

All cancellations must be made at least 24 hours in advance in order to allow for rescheduling. If at any point your child's attendance falls below 75%, your child may be removed from the schedule and placed on our wait list. If your child misses 3 appointments in a row without a valid cancellation, he or she will be taken off of the schedule.

BACH Buster's Kids reserves the right to discharge a patient based on non-compliance. If you know that your child will be out for an extended period of time please notify a staff member so that your child can be placed on a temporary hold.

Please note: this cancellation policy does not apply if a session is cancelled due to therapist being out and/or a clinic closure. BACH Buster's Kids will attempt to reschedule these cancellations at a time that is convenient for you. BACH Buster's Kids will be closed on the following holidays: New Years Day, Good Friday, Memorial Day, Independence Day, Labor Day, Presidents Day, Thanksgiving Day, Friday after Thanksgiving, Christmas Eve, and Christmas Day.

It is the duty of BACH Buster's Kids staff and the parent/guardian to prevent the spread of communicable diseases. Therefore, if your child or their therapist is sick, the therapy session should be cancelled and rescheduled if possible. The following is a list of illnesses that indicate the need for cancellation:

- | | | |
|--------------------------------------|-----------------------|-----------------------|
| Diarrhea or vomiting within 24 hours | Viral gastroenteritis | Whooping Cough |
| Fever over 100° within 24 hours | Head lice | Polio |
| Chicken Pox | Hepatitis A | Ringworm of the scalp |
| Conjunctivitis | Impetigo | Salmonella |
| Diphtheria | Influenza | Scabies |
| Fifth disease (with fever) | Measles | Shigellosis |
| | Bacterial Meningitis | Strep throat |
| | Mumps | Tuberculosis |

I, _____, parent/guardian of _____, have read the above stated attendance policy. I understand and agree to the above policy for my child.

Printed Name of parent/guardian: _____

Signature: _____

Date _____

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Drop off/Pick up policy

I understand that I must remain inside the BACH building throughout my child's entire therapy session(s). I understand that this is for the safety of my child and/or in the event of an emergency. I will remain in the building to pick up my child and consult with his/her therapist. If myself or another guardian are unable to attend a session, I agree to provide contact information and written consent for the therapist(s) to consult with anyone other than myself who will accompany my child to and from therapy prior to appointment. I agree that if my child has a tracheostomy or vagal nerve stimulator, myself or another caregiver for my child for whom prior consent had been provided will remain in therapy session or Buster's Kids waiting room throughout my child's session in case I am needed.

Printed name of Parent/Guardian:

Signature of Parent/Guardian:

Date:

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Consent of Release/Request for Information

I consent to the release of information and/or disclosure of information to BACH Buster's Kids of all or any part of my child's medical record by any physician, hospital, school or other facility as listed below. This consent to release information includes but is not limited to medical/hospital records, evaluations, assessments, progress notes, 504 accommodations, must provide Latest THsteps, Hearing Test results, Audiology report if failed hearing test, Doctor notes indicating patient need and referral of Speech Therapy. and provides permission to consult with person/organization.

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Primary Care Physician, Referring Physician or Specialist Information:

Name of PCP person/organization: _____

Address: _____ Phone: _____ Fax: _____

Name of referring physician or specialist: _____

Address: _____ Phone: _____ Fax: _____

Name of referring physician or specialist: _____

Address: _____ Phone: _____ Fax: _____

**I understand that my consent is voluntary and can be withdrawn at any time. This authorization is valid until consent is withdrawn in writing or the following specific date: _____

Parent/Guardian Name: _____ (printed)

Parent/Guardian Name: _____ (signature)

Date: _____

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Media Release Form

BACH Rehab Center and Buster's Kids frequently host community events that you and your family will be invited to. At these events, there may be photos and videos taken to document these events and it is important that BACH Rehab Center has permission to take and use these photographs. You have the right to deny this request; however, BACH does not take responsibility for photographs taken by the media or by persons unaffiliated with BACH at these events.

I, _____, consent that BACH Rehab Center, its employees or agents have the right to take photographs, videotape, and/or digital recordings of my child, _____, and beginning on _____ for the following purposes selected:

- BACH's Website
- BACH Marketing
- To display in BACH facility
- BACH's social media
- Instruction and continuing education (via therapy providers)

I waive all rights to the aforementioned media. I understand that there will be no financial compensation for using the aforementioned media. BACH Rehab Center is not responsible for any expense of liability incurred as a result of my child's participation in this photography.

I understand that my consent is voluntary and can be withdrawn at any time. This authorization is valid until consent is withdrawn in writing or the following specific date: _____

Printed name of parent/guardian: _____

Signature of Parent/guardian: _____

Date: _____

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Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of BACH Rehab Center/BACH Buster's Kids.

Name of patient:

Name of parent/guardian:

Signature of parent/guardian: _____

Date: _____

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Financial Policy

BACH Buster's Kids requires all payment at the time of service. We accept personal checks, cash, or credit/debit cards. Our billing specialist will electronically file claims and consult with you regarding the progress of claims as needed. We urge you to discuss with us any questions that you may have regarding our services and fees. If you anticipate problems with your insurance coverage or personal payment, please contact our billing specialist. The earlier we know about a possible problem, the easier it will be to assist you. Please notify us of any changes in insurance as soon as possible. Failure to do so may result in full responsibility of payment and/or termination of services.

Monthly Statement

Payment is due at the time of service; however, if you have a balance on your account, you will receive a statement monthly. All balances are expected to be paid in full. If your account becomes past due, we reserve the right to refer your account to collections. Payments made will be applied to the oldest outstanding balance first.

Insurance

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your responsible portion. It is then your responsibility to pay any portion of the charges not covered by insurance. If a claim is denied by your insurance company, BACH will appeal the decision; however, you are ultimately responsible for all charges not paid or denied by your insurance company.

Cessation of Insurance Coverage/Non-covered Services

If your insurance terminates or does not cover a billed service, you will have the option to pay out of pocket. The current out of pocket cost for services are \$180 for evaluations and \$70/\$90 per therapy visit. These rates are subject to change at any time. Please discuss any special circumstances with Buster's Kids Director.

If you choose to pay privately, we will stop billing your insurance and you will be responsible for this agreed upon rate.

By signing below, you agree to the above stated financial policy regarding insurance, payments, and private pay rates. If at any time you have any questions, please contact BACH Buster's Kids for assistance.

Printed Name of parent/guardian:

Signature: _____

Date _____

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Assignment of Benefits

I _____ hereby assign all benefits for which I am entitled by my insurance carrier, _____, to BACH Rehab Center. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I hereby authorize BACH Rehab Center to release any necessary information acquired in the course of my examination or treatment to my referring physician, health plan/insurance representative or attorney.

I hereby authorize BACH Rehab Center to initial a complaint on my behalf to The Chief Insurance Commissioner and The Internal Review Processing Board of _____ for untimely processing of insurance claims.

I hereby authorize payment directly to BACH Rehab Center for all services rendered.

Signature _____

Date _____

Witness _____



Dear Parent or Guardian,

Brazoria County Association for Children's Habilitation (hereafter noted as BACH) operates a program called Buster's Kids (hereafter noted as BK).

It is the intention of BACH's BK program to ensure that each child's therapy program is productive, provides the best opportunity for the child to meet the stated goals, and helps them develop to their full potential. Please assist us in providing these services by notifying us in advance of cancellation or schedule changes. Cancellations must be made by calling our office at 979-849-2447.

CANCELLATION POLICY

(Please note the cancellation policy does not apply if a session is cancelled due to therapist being out or for clinic closure. BK will attempt to reschedule these cancellations at a time that is convenient for you.)

Your appointment time has been reserved specifically for you and your child. Once your appointment is scheduled you are responsible for providing a 24-hour notice of cancellation. It is important to note that insurance companies do not provide reimbursement for sessions you do not show up for, so your therapist is unpaid when you do not come to your session.

Because we know that emergencies arise occasionally at the last minute, we will forgive two late cancellations or no-shows per six-month period. Upon the third cancellations or no-show, your child will be removed from the schedule and placed on the wait list. After three valid cancellations (canceled within the 24-hour window) your child will be removed from the schedule and placed on the wait list. We do recognize that often a child will show symptoms of illness suddenly and a 24 hour notice is not always possible. We will address this on a case by case basis with ample reminders and warnings. ****Please also note, poor attendance can in many cases impact your insurance approval and can resulted in services being denied or being reduced.****

Please initial that you have read and agree to the following:

_____ I understand that I must provide a 24-hour notice of cancellation of my child's appointment.

_____ I understand that I get two "penalty-free" cancellations or no-shows within a six-month period, but if a third one occurs, my child will be removed from the schedule and placed on the wait list.

_____ I understand that after three valid cancellations, within the 24-hour window, in a six--month period, my child will be removed from the schedule and placed on the wait list.

_____ I understand that I must notify BACH to reschedule if my child exhibits any of the following: diarrhea or vomiting within 24 hours, fever over 100 within 24 hours, chicken pox, conjunctivitis, diphtheria, fifth disease, viral gastroenteritis, head lice, hepatitis A, impetigo, influenza, measles, bacterial meningitis, mumps, whooping cough, polio, ringworm, salmonella, scabies, shigellosis, strep throat, tuberculosis, COVID-19 or symptoms of COVID-19.

I, _____, parent/guardian of _____ have read the above stated policy. I understand and agree to the above policy for my child.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 5/01/2017 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you or your child for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your child's health information to obtain payment for services we provide to your child.

Payment: We may use and disclose your child's health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your child's health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered via telehealth after May 1, 2017. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

healthcare operations and certain other activities for the last 3 years, but not before May 1, 2017. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative Communication: You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. (you must make your request in writing) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your child's health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in Written form.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your child's health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the complaint information listed at the end of this Notice.

We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint.

Contact Officer: Shelly Briones-Gonzales

Telephone 979-849-2447

e-mail sbriones@bacheci.org Fax 979-848-8337

Address 120 E. Hospital Dr., Angleton, Texas 77515