CHILDREN'S THERAPY CENTER
Celebrate what is. Commit to what can be.

Child's Name:
Date of Birth:

Welcome to Children's Therapy Center! We hope you will find CTC to be a warm and welcoming environment for you and your child. Enclosed is the paperwork needed for your visit. Please complete it thoroughly. Let us know if you have any questions or if we can assist you in any way.

ACKNOWLEDGEMENT OF POLICIES AND NOTICE OF PRIVACY PRACTICES

ATTENDANCE POLICY: Since this time is reserved for you and your child, attendance is very important. We understand that illness, medical appointments, travel, and life circumstances create valid reasons for missed appointments; however, we cannot hold recurring appointment times for families who are frequently absent. Please keep the following in mind:

In order to keep the appointment time reserved for you and your child, you must maintain good attendance. We would appreciate at least 24 hours' notice if you are going to miss an appointment. **We require at least 4 hours' notice in advance of missed appointments**. We also ask that you attend at least 75% of your scheduled appointments. Appointments that are missed without calling at least 4 hours prior to your appointment or an attendance rate under 75% will result in the rest of your appointments being cancelled**.**

Thank you for your consideration with regards to appointment attendance.

ASSIGNMENT OF INSURANCE BENEFITS & FINANCIAL AGREEMENT: In order to bill your insurance, all children need a doctor's prescription and insurance authorization prior to their first appointment. Our billing department will work to obtain this information and will contact you with any questions or concerns. We encourage you to contact your insurance company to understand your individual benefits. If you have a co-pay, it will be due at the time of your appointment. Please be sure to inform us of any changes in your insurance plan so that we can continue to bill your insurance appropriately. If you fail to give us prior notice of any change of insurance coverage you will be held responsible for any charges accrued.

NOTICE OF PATIENT PRIVACY PRACTICES: Children's Therapy Center's Notice of Patient Privacy Practices describes how your medical information may be used and disclosed, and how you can get access to this information. Please review this information. CTC reserves the right to update its practices regarding the protected health information that it maintains. You may request a copy of CTC's Notice of Patient Privacy Practices at any of our locations, or online at www.ctckids.org.

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1. By signing below, I hereby assign and authorize payment of medical insurance benefits, in an amount not to exceed the charges for its services, directly to Children's Therapy Center. I understand that it is my responsibility to inform the organization of any changes to my insurance. I also understand that I am financially responsible for any charges not paid under this assignment and agree to pay such charges.
2. By signing below, I acknowledge that I have read and understand Children's Therapy Center's attendance policy, assignment of benefits, financial agreement, and privacy practices.

Signature of Parent or Legal Guardian Date

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Phone: 253-854-5660
Fax: 253-854-7025
www.ctckids.org

Kent
10811 SE Kent-Kangley Rd.
Kent WA 98030

Burien
127 SW 156th St.
Burien, WA 98166

Tacoma
8717 S Hosmer St.
Tacoma, WA 98444

RELEASE OF INFORMATION

I, **(Parent/Guardian)**_____, hereby grant consent for Children's Therapy Center to give and/or receive information pertaining to the Physical/Occupational/Communication/Oral Motor Therapy, Prosthetic/Orthotic programs and/or Education programs for (**Child's Name**) _____ **(other names known by)** _____ (**Child's Date of Birth)**_____ with the professionals or agencies listed below for the purpose of coordination of care. Records released may include all information concerning any testing, diagnosis or treatment related to HIV, STD, psychiatric and/or drug/alcohol. A photocopy of this document shall be considered to be as valid as the original.

Please list names of people who help you with your child, including primary physician, public health nurse, therapists, specialists, day care staff, and other agencies:

Contact Person's Name	Agency/Clinic Name and Address	Phone #
Doctor (Primary):		
Doctor (Other):		
Hospital:		
Public Health Nurse:		
School District:		
Caseworker:		
Physical/Occupational/Speech Therapist:		
Childcare/Daycare Provider:		
Other:		

Rights: I understand I do not have to sign this release in order for the patient to receive services (treatment, evaluation, or enrollment). However, I do have to sign a release form in order for the organization to share information regarding the patient on my behalf. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

_____ _____ _____
Signature of Parent or Legal Guardian **Relationship to Child** **Date**

Expiration: This release will be valid for the patient's duration of participation in our programs and will expire one year after the patient's discharge. This release may be revoked at any time by the above signed through submission of a written and signed statement. Revoking this release of information will not impact information released prior to the date of the written revoke request.

Children with Special Health Care Needs
CHILD HEALTH INTAKE FORM

☐ Case Management ☐ CSHCN Eligible				☐ New ☐ Renewal
CHILD'S NAME (LAST, FIRST, MI)	2. DOB	3. SSN	4. SEX	5. RACE/ETHNIC PREFERENCE
6. FATHER/GUARDIAN/FOSTER PARENT NAME	7. DOB	8. SSN	9. FAMILY SIZE	LANGUAGE 10. 11.12.13.
14. MOTHER/GUARDIAN/FOSTER PARENT NAME	15. DOB	16. SSN	16A. MOM'S EDUCATION LEVEL	17. REFERRED BY
19. ADDRESS CITY STATE ZIP	20. PHONE (Home)	21.PHONE (Work)	22. PHONE (Message)	18. INCOME: UNDER / OVER 200% FPL

24. OTHER DEPENDENTS IN HOUSEHOLD	25. RELATIONSHIP	26. DOB	27. PRIMARY PHYSICIAN/ADDRESS/PHONE
			28. DIAGNOSIS/MEDICAL PROBLEMS/ICD-9
			29. ICD-9-CODE(S)

30. NOTES / COMMENTS	30(A).	31. CHIF DATE
	33. MEDICAL HISTORY	

32. REASON FOR REFERRAL	35. HEALTH/MEDICAL INSURANCE ☐ INSURARANCE Name: _____ Group #: _____ ☐ INSURARANCE Name: _____ Group #: _____ ☐ CHAMPUS/TRICARE: _____ _____ Group #: _____ ☐ MEDICAL COUPONS: _____ PIC # / CASE #: _____ _____ _____ ☐ OTHER: _____ _ _____
34. OTHER HEALTH CARE SPECIALISTS/PROVIDERS	

36. AGENCY INVOLVEMENT: (Please check all that apply)

☐ WIC ☐ SSI ☐ SSS ☐ DDD ☐ FOSTER CARE ☐ SCHOOL/IEP/IFSP_____ ☐ GS-CTU ☐ MB-NDP

☒ CHILDREN'S THERAPY CENTER-TACOMA ☐ _____ ☐ _____ ☐ BIRTH TO THREE DEV CTR FW

AGENCY SUBMITTING THIS CHIF: CHILDREN'S THERAPY CENTER – TACOMA

DO NOT WRITE IN SHADED AREAS

Submitting Agency: Please return this completed form to: Children w/Special Health Care Needs Program in Client's County

As a nonprofit agency, we receive funding from United Way. We are requested by United Way to collect demographic information for participants in our program. This survey does not include your name so that your identity is totally confidential. Please take a few moments to complete this form. Thank you!

Client Demographic Form July 2016 - June 2017

Instructions: *Please write clearly. Enter numbers or mark **X** in the appropriate boxes.*

1. Geographic Region:
We live in
Zip Code: 9 8 ☐ ☐ ☐

We live OUTSIDE the city limits:
☐ YES ☐ NO

2. Household Composition
Please check one:
- ☐ Two parent household
- ☐ Single parent (male)
- ☐ Single parent (female)
- ☐ Other related household

3. Total Gross Household Income
Please check one **based on the chart below**:
- ☐ Under 30% of Median Income (A)
- ☐ Under 50% of Median Income (B)
- ☐ Under 80% of Median Income (C)
- ☐ Equal or Above 80% of Median Income (D)

4. Are you currently homeless? (check one)
☐ YES ☐ NO

5. Child's Age: ☐☐ **Years** ☐☐ **Months**

6. Child's Gender: (check one)
☐ Female ☐ Male

7. Ethnicity:
Child is Spanish / Hispanic / Latino
☐ YES ☐ NO

8. Child's Race: (check all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian, Asian American
- ☐ Black, African American, Other African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Caucasian
- ☐ Other

9. Limited English Proficiency
Are you (parent/adult) limited in your ability to communicate in English? (check one)
☐ YES ☐ NO

REVISED 04/17

King County - HUD Income Guidelines - 2016

Instructions: Under FAMILY SIZE, choose the row for the number of people in your household. Select the income range in that row for your ANNUAL GROSS INCOME for last year. The letter above that column will be your income category.

	Percent of Median Income			
	30% HUD PMSA	50% HUD PMSA	80% HUD PMSA	Over 80% HUD PMSA
FAMILY SIZE	Very Low	Low	Moderate	Above Moderate
↓↓↓	Category A	Category B	Category C	Category D
1 Person	Up to $ 19,000	$ 19,001 to $ 61,650	$ 61,651 to $ 48,550	$ 48,551 or more
2 Persons	Up to $ 21,700	$ 21,701 to $ 36,150	$ 36,151 to $ 55,450	$ 55,451 or more
3 Persons	Up to $ 24,400	$ 24,401 to $ 40,650	$ 40,651 to $ 62,400	$ 62,401 or more
4 Persons	Up to $ 27,100	$ 27,101 to $ 45,150	$ 45,151 to $ 69,300	$ 69,301 or more
5 Persons	Up to $ 29,300	$ 29,301 to $ 48,800	$ 48,801 to $ 74,850	$ 74,851 or more
6 Persons	Up to $ 32,580	$ 32,581 to $ 52,400	$ 52,401 to $ 80,400	$ 80,401 or more
7 Persons	Up to $ 36,730	$ 36,731 to $ 56,000	$ 56,001 to $ 85,950	$ 85,951 or more
8 Persons	Up to $ 40,890	$ 40,891 to $ 59,600	$ 59,601 to $ 91,500	$ 91,501 or more

FY 2016, Median 4 Person Family income = $90,300
HUD (U.S. Department of Housing and Urban Development) rev 8/2016
PMSA (Primary Metropolitan Statistical Areas)

United Way
King and Pierce County

Thank you for your reply.

Your information will be kept completely confidential.

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Child's Name _____ **DOB** _____

School/Preschool _____ **Grade** _____

Does your child have an IEP at School? **Yes** **No**

What are your primary concerns regarding your child's development?

Please list any medical diagnoses given to your child (Down Syndrome, Cerebral Palsy, Autism, reflux, allergies, etc.):

Any allergies/food sensitivities?

Please list other specialists or facilities where your child is followed (Children's Hospital, Mary Bridge, GI clinic, WICC, Neurologist, etc.)

Has your child had any significant illness, injury or hospitalization(s) that we should be aware of?

Please list any medications your child takes:

Was your child late to meet any of their developmental milestones? (sitting, walking, speaking, toilet training, feeding, reading, etc.)

Does your child have any hearing or vision issues/concerns?

Has your child had any previous evaluations? (physical therapy, occupational therapy, speech therapy, feeding, school, etc.)? Please list where and approximate dates.

Parent/ Guardian Signature _____Date _____