CASE HISTORY FORM

Patient Name: ____ D.O.B.: ______________________

Address: ____ Phone: ______________________

City: ___________________________ State: ___________ Zip Code: ____________________

Insurance: ______________________ ID: _________________ SS#: ______________________

____

MAIN COMPLAINT - SINCE WHEN?

____

____

____

____

MEDICAL HISTORY

Describe any major accidents or hospitalizations: ____

____

Does the patient have any medical diagnoses? (e.g., Autism, Dyslexia, Developmental Delay)?

____

____

Is the patient taking any medications? ____ No ____ Yes, Explain: _______________________________

____

Does the patient have any known allergies? ____ No ____ Yes, if yes identify: ____________________

____.

BEHAVIORAL HISTORY

Please check all that describe you:

___Friendly
___Easy going
___Aggressive destructive
___Attentive
___Poor memory
___Sleeps well
___Impulsive/Impatient
___Difficulty sleeping
___Doesn't like read
___Has temper tantrums
___Willing to try new activities
___Defiant
___Separation difficulties
___Poor eye contact
___Hyperactive
___Daydream
___Unpredictable
___Eats well

MEDICAL HISTORY

___Will not eat certain textures
___Will not touch certain texture
___Cannot easily shift from one activity to another
___Withdrawn
___Bites nails
___Plays alone for reasonable amount of time
___Doesn't like to be touched
___Stubborn Still
___Talkative
___Overly sensitive emotionally
___Bad-tempered
___Has nightmares
___Uses pacifier/sucks thumb
___Grinds teeth
___Clumsy
___Cries easily
___Wets bed
___Easily frustrated
___Distractible/short attention span
___Mouth breather
___Restless
___Shy
___Snores
___Quiet
___Often sensitive to sound

PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

AUTHORIZATION AND RELEASE FORM

I, ___________________________________, patient/client legally authorize, PLAY PALS THERAPY, INC. to evaluate for Mental Health/Psychology services. I also authorize PLAY PALS THERAPY, INC. to release medical records to

____.

______________________________	____________________________
Patient name	Date
______________________________________	____________________________
PATIENT/ RESPONSIBLE PARTY SIGNATURE	Date

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TREATMENT AUTHORIZATION

Having a condition requiring diagnostic and treatment, I do hereby voluntarily consent to such diagnostic procedure and treatment by PLAY PALS THERAPY, LLC. I am aware that therapy is not an exact science and I acknowledge that no guarantees have been made to me because of treatment. I have read this form and certify that I understand its full content.

______________________________ ____________________________

Patient Name Date

___________________________________ ____________________________

PATIENT/ RESPONSIBLE PARTY SIGNATURE Date

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PAYMENT POLICY

1. Payment is expected at the time services are tendered unless other arrangements were made in advance and approved by Director.
2. If services are billed, the terms are “Net 30”, meaning that payment in full is expected within 30 days of the date of the bill.
3. PLAY PALS THERAPY LLC., will help in the filling of Insurance claims, but the recipient of services is ultimately responsible for payment of the bill.

_______________________________ _____________________________

Patient name Date

___________________________________ _____________________________

PATIENT/ RESPONSIBLE PARTY SIGNATURE Date

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CANCELLATION POLICY

Due to the overwhelming need for our services, it is our policy to discharge those who are unable to make the necessary commitment to therapy. A client will be discharged after the third consecutive absence, (i.e., cancellation not made 24 hours ahead of time), or when attendance has dropped to 50% in any 30-day period.

Unless specifically exempted to do so by law, we reserve the right to charge any cancellations not made 24 hours ahead of time to your account. You will be fully responsible for paying the charge for non-canceled sessions. Your insurance will not pay for it. If we know you are unable to attend your session in advance, we can make the necessary adjustments to our schedule.

______________________________ ______________________________

Patient name Date

______________________________ ______________________________

PATIENT/ RESPONSIBLE PARTY SIGNATURE Date

NO SHOW FEE

IMPORTANT NOTICE FOR ALL PATIENTS

AVISO IMPORTANTE PARA TODOS LOS PACIENTES

Effective Immediately…

Everyday there are patients who do not show up for their appointments.
That creates a problem for other patients, who want to come in sooner and can't, due to the lack of open slots on the schedule, and for the office.
Therefore, we will charge you a $25.00 "No Show Fee". If you don't call in advance to cancel or reschedule if you can't make it to your appointment.
Please be considerate with other patients, the office and call at least 24 hours in advance if you are not coming.

I understand that I will be charged with a "No Show" fee in the amount of $25.00, this fee will be collected prior to being seen in your next scheduled appointment.

Thank you,

Efectivo Inmediatamente…

Todos los días hay pacientes que no vienen a su cita programada.
Esto continúa creando problemas para la oficina y para los pacientes, que necesitan una cita y no la obtienen por falta de espacio.
Por esta razón vamos a cobrarle $25.00 por faltar a su cita y no dar aviso previo de que no podía asistir.
Por favor piense en otros pacientes que necesitan su ayuda y si no puede venir avise por lo menos con 24 horas de anticipación.

Entiendo que se me cobrara $25.00 sino cancelo la cita programada con la debida anterioridad. Este valor se cobrara antes de entrar a su próxima cita programada.

Gracias

PRINT PATIENT NAME (NOMBRE DEL PACIENTE): ______________________________

PATIENT SIGNATURE (FIRMA DEL PACIENTE): ______________________________

DATE (FECHA): ______________________________

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PADRES, SI FIRMÓ LA POLÍTICA DE CANCELACIÓN, HABRÁ UN CARGO DE $ 25.00 POR CADA TERAPIA QUE NO SE PRESENTE O QUE NO SE CANCELE 24 HORAS ANTES.

PARENTS, IF YOU SIGNED THE CANCELLATION POLICY, THERE WILL BE A $25.00 FEE FOR EACH MISSED THERAPY SESSION FOR NOT SHOWING UP OR FOR NOT CANCELING 24 HOURS BEFORE.

____

PATIENT OR RESPONSIBLE PARTY SIGNATURE