EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

760-271-1874
855-251-8779
info@ebscisd.com
www.ebscisd.com
411 Camino Del Rio South, Suite 101 | San Diego, CA 92108

Client History Form

General Information

Child's Full Name: _____ DOB: _____

Parent or Caretaker's Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Is this address the same as your billing address? ☐ Yes ☐ No

If no please provide both your billing address: _____

_____

Who lives in the home with you? _____

Spiritual or Cultural considerations you want to share that may impact therapeutic decisions?

_____

Relationship to Patient: _____ Primary Phone: _____ Alternate Phone: _____

Email: _____

Full Custody_____ Other_____ if other, please provide a copy of the custody agreement

***if partial or joint custody, both parties will need to consent to treatment**

Alternate Email and Relationship to Patient:

_____

Language(s) spoken at home: _____

How did you hear about EBS Children's Institute? _____

Emergency Contact Information

Emergency Contact Name 1: _____

Relationship to Patient: _____Phone: _____

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Emergency Contact Name 2: _____

Relationship to Patient: _____Phone: _____

Present Medical Information

Describe present concern related to appointment:

_____

_____

_____

Have any previous therapies or approaches been attempted? ☐ Yes ☐ No

If yes please describe: _____

Has there been any significant medical or behavioral changes in the past 6 months? ☐ Yes ☐ No

If yes, what has changed? _____

Please list any allergies: _____

What is your child's current health? ☐ Good ☐ Fair ☐ Poor

Is your child taking any medications? ☐ Yes ☐ No If yes what? _____

Does your child have any other medical diagnosis or concerns? _____

Does your child have any adaptive or medical equipment? _____

Indicate any illnesses, accidents, hospitalizations (include age/treatment): _____

_____

Does your child have problems hearing? ☐ Yes ☐ No

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If yes, please explain: _____

Has your child experienced any ear infections? ☐ Yes ☐ No

Approximately how often? Rarely Occasionally Often

Has your child had middle ear tubes inserted? ☐ Yes ☐ No

If yes, when? _____

Has your child's hearing ever been tested? ☐ Yes ☐ No

Results: _____

Did your child have his/her adenoids or tonsils removed? ☐ Yes ☐ No

If yes, when? _____

Does your child snore? ☐ Yes ☐ No

Does your child wear corrective lenses (glasses, contacts)? ☐ Yes ☐ No

If yes, at what age did your child begin to wear them? _____

Therapy Goals

Please describe your goals for therapy. What do you hope to accomplish? _____

_____

Are you in need of any additional supports besides what you are being seen for today? ☐ Yes ☐ No

If yes, please describe: _____

Birth History

Was pregnancy full term? ☐ Yes ☐ No

Was there anything remarkable about the mother's health during pregnancy or delivery? ☐ Yes ☐ No

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If yes, please explain: _____

Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Breech ☐ Suction ☐ Forceps

Was there any type of diagnosis or medical concern about the baby after birth? ☐ Yes ☐ No

If yes, please explain: _____

Please describe any family history of developmental or learning problems:

_____

_____

Education/Therapy Information

Is your child enrolled in any type of childcare facility, preschool program, play group, developmental program, public school or private school? ☐ Yes ☐ No

Name of School/Facility: _____ How long have they attended? _____

Hours enrolled per week: _____ Current Grade Level: _____

Has your child ever had a school based evaluation? ☐ Yes ☐ No

Please briefly describe the results: _____

_____

Does your child have an IEP? ☐ Yes ☐ No

What type of services do they receive? _____

Please provide a copy of the IEP and Evaluation to EBS Children's Institute.

Does your child receive speech/occupational/physical/counseling therapy at this time? ☐ Yes ☐ No

Speech Therapy _____x/week

Occupational Therapy _____x/week

Physical Therapy _____x/week

Counseling _____x/week

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Where are these services provided? _____

Referral source:
Contact Information:

Any relevant legal issues

Medical History

Does your child have any medical diagnosis?
Does your child have any diagnosis? If yes, please list with date of diagnosis:
Physician/ Agency:
Age at Diagnosis:
Recommendations made:

Does your child have a seizure disorder or any history of seizures?:

How many hours does your child sleep at night?

Does your child take naps?

If yes, how many hours does your child nap? Duration? Start/ end time?

Does your child have any difficulty staying asleep?

Are there any other factors interrupting your child's sleep?

Dietary interventions/ special diets current or past? If yes, please explain:

Is your child a picky eater? If yes, please describe:

What foods will your child eat?

What foods will your child not eat?

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Motor information

Rate the following poor, fair, or good:

Balance:

Manual skills (crayons, buttons, etc.):

Physical abilities (running, jumping etc.):

Physical endurance (running, outside play):

Does your child seek out physical activities? If yes, please explain (crashing into furniture, rough housing, etc.):

Does your child avoid physical activities? If yes, please explain:

Does your child appear stiff and rigid?

Does your child appear loose and floppy?

Other pertinent motor information:

Communication Information

At what age did your child first use words?

When was a problem first noticed (please describe)?

Speech-language diagnosis? (Aproxia, receptive/expressive language disorder):

How does your child primarily communicate (1-word phrases, gestures, signs?):

If your child is using spoken words, what is the approximate length of the phrase:

Does your child have echolalia?:

Does your child use spontaneous communication?:

Do you have difficulty understanding your child's speech?:

Do other people have difficulty understanding your child's speech?:

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Social and behavioral History

How would you describe your child's personality?:

How would you describe your child's play?:

Favorite play activities and interests?:

Does your child play with other children? If yes, please describe:

Does your child behave well in public places? Please describe:

How many hours of TV does your child watch each day?

Are the following behaviors a concern? If yes, please describe

Aggression

Tantrums

Anxiety

Impulsivity

Difficulty with attention

Hyperactivity

Difficulty controlling emotions

Self-stimulatory behaviors (hand flapping, spinning)

Repetitive vocal/ verbal behaviors

Rituals and/or routines

Any additional behaviors of concern? Please describe:

Is your child toilet trained?

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Schedule

Please use the chart below to show child's schedule and availability. Please include any relevant information such as naps, school, regular appointments (speech, OT, PT, tutors, etc).

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 am							
9:00 am							
10:00 am							
11:00 am							
12:00 pm							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							
7:00 PM							

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Informed Consent

Child's Name: _____

CONSENT FOR THERAPEUTIC TREATMENT
I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Institute. I understand that I may terminate these services at any time**.**

_____ _____
Signature of Parent or Guardian Date

INVOLVEMENT IN CARE AND SERVICES
EBS encourages all clients and families to be an active member of the therapy session. Parent training and home generalization programs are critical for success and progress. I agree to be an active member of my child's treatment plan.

_____ _____
Signature of Parent or Guardian Date

IF SHARED CUSTODY- both parties must sign this consent prior to treatment

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at EBS Children's Institute. I understand that I may terminate these services at any time**.**

_____ _____
Signature of Parent or Guardian Date

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT
Intervention programs at EBS Children's Institute usually involve the use of specialized equipment such as various swings, bolsters, inflated therapy balls, climbing structures, tactile media (such as soap foam, Play-Doh and lotion), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new in order to foster increased skills and abilities. While EBS staff make great efforts to ensure each child's safety, the nature of the therapeutic intervention includes the risk of falling, bumping into other people/equipment. I am aware of the inherent risk of this type of activity, and I give permission for my child to participate in therapy as described.

_____ _____
Signature of Parent or Guardian Date

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REVIEW OF RECORDS/RELEASE OF INFORMATION

I consent to communication between EBS Children's Institute and other therapists, teachers, and/or doctors that have previously worked and/or are currently working with my child. I understand that information and documentation may be shared with another member of my child's treatment team outside of EBS, as well as shared with professionals within EBS as part of the treatment process.

I understand that the information that is released between the treatment providers is confidential and is for the well -being of my child.

_____ _____

Signature of Parent or Guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR THERAPEUTIC PURPOSES

Therapists often videotape or photograph children who receive therapy services at EBS to help monitor and document a child's areas of concern, as well as progress. Videotapes and photos are used and reviewed only by EBS staff. Parents are welcome to view their child's videotape at EBS.

I do____do not_____give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use by EBSCT staff only.

_____ _____

Signature of Parent or Guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR EDUCATIONAL & PUBLIC AWARENESS PURPOSES

Staff at EBS are frequently asked to teach at courses, seminars or workshops. We often like to include videotape, slides or photos during our presentations. Additionally, we may occasionally use photographs to share on Social Media and for promotional purposes

I do___do not____give permission for my child to be videotaped/photographed for educational and public relations purposes. I understand that my child's name and any identifying information, will not be used in association with these images.

_____ _____

Signature of Parent or Guardian

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Cancellation and Tardiness Policy 2020

Consistency is vital to a successful outcome in the therapy process. In the event that your child is unable to attend sessions regularly, we will work with you and make every effort to accommodate your family's needs by seeking to develop a solution that is in the best interest of your child. **If your child's attendance continues to be inconsistent and is no longer therapeutically appropriate, therapy may be placed on hold until consistency can be improved. Please review the guidelines below regarding the cancellation and tardiness procedures:**

Cancellation Policy: Your child's therapist has reserved valuable time for your child's treatment. Your therapist has prepared for the session and blocked out all other activity during this time. In the event that a therapy session is missed with less than 24 hour notice, a fee of $35 will be assessed to the family. If there are more than three absences without proper notice, in a period of six months, your appointments will be at risk for permanent suspension.

Illness: Please call your child's assigned Supervisor as soon as you know that your child may miss your scheduled session. Refer to the illness policy for additional information.

Vacation: Please inform the assigned Supervisor at least two weeks prior to absence due to vacation.

Other: Routine Dr.'s visits, meetings and other flexible appointments should be scheduled so they do *not conflict* with *the existing therapy appointment.* Therapy is an important part of your child's schedule, and should be treated as such.

We understand that there are unavoidable instances that require cancellation of the session (illness, family vacation out of town, death in the family, etc.) and we are willing to work with families during these occasional circumstances. Chronic illness will be taken into consideration for continuation of therapy.

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Cancellation and Tardiness Policy 2020

Illness Policy

Please understand that, while attendance is vital, it is also important to protect your child, as well as the health of the therapist and other children. We require children to be symptom and fever-free for at least 24 hours prior to returning for a session. If a child is on an antibiotic for an illness, the medication must be administered for at least 24 hours before sessions can resume. Please call your assigned Supervisor as soon as you know that your child may miss your scheduled session due to illness.

The following circumstances warrant cancellation (with possible rescheduling) of the therapy session:

- The child is unusually lethargic or irritable
- Presence of yellow or green mucus secretion
- Vomiting/diarrhea
- Fever (within 24 hours of session)
- Seizures
- Open skin sores
- Head lice or nits present
- The child is in a contiguous state of a communicable disease including by not limited to:
    - Pink Eye
    - Explained rash
    - Strep Throat
    - Chickenpox
    - Ringworm - must be 24-48 hours on treatment and completely covered if rash is still present.

HIPAA Notification Policy

Please review our Notice of Privacy Practices carefully.
The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed and how you can get access to this information.

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Cancellation and Tardiness Policy 2020

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (09/01/2003), 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 this Notice.

Uses and Disclosures of Health Information

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

For example:_____

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your 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.

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Your Authorization: In addition to our use of your 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities. If we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

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National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as e-mail and voicemail messages, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.35 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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

Amendment: You have the right to request that we amend your 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 Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

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Cancellation and Tardiness Policy 2020

Questions and Complaints

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

Phone: 800-578-7906 ext. 1213
Email: Katie.Killeen@ebsei.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. I have *received a copy* and agree to abide by the terms of EBS Children's Institute:

- **Cancellation/ Tardiness Policy**
- **Illness Policy**
- **HIPAA Notification Policy**

I acknowledge that I have received the Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPAA Privacy Regulations, how EBSCI may use and disclose my child's protected health information to carry out treatment, payment or health care operations and for the other specific purposes that are permitted or required by law. The Notice also describes my rights and EBSCI's duties with respect to protected health information about my child.

_____ Child's Name

_____ Signature of Parent or Guardian

_____ Date

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Cancellation and Tardiness Policy 2020

Notice of Privacy Practices

Section A: To the Patient – *Please read the following statements carefully*.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations (TPO).

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

With my permission the office of ***EBS CHILDREN'S INSTITUTE*** may call my home or other designated location and leave messages on voicemail that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my permission the office of ***EBS CHILDREN'S INSTITUTE*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient invoices and statements.

With my permission, the office of ***EBS CHILDREN'S INSTITUTE*** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder and patient invoices and statements.

I have the right to request that ***EBS CHILDREN'S INSTITUTE*** restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

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You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: 800-578-7906 ext. 1213 | Email: Katie.Killeen@ebsei.com

Section B: Parent or Guardian Giving Consent (if Patient is not 18 years of age and their own guardian)

Name:_____Date: _____

Relationship to Patient:_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation submitted to ***EBS CHILDREN'S INSTITUTE attn.: Katie Killeen.*** Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may *decline* to treat you or to continue treating you if you revoke this Consent.

I,_____, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Child's Name: _____

Signature: _____

Date:_____