## CHILD CASE HISTORY FORM

Patient Name: ________________________________________ D.O.B.: _______________________ Age: __________

Address: ______________________________________________________ Phone: ____________________________

City: ________________________________ State: _______________ Zip Code: ______________________

Insurance: ____________________________ ID: _________________________ SS#: ________________________

Date: ____________________ Your name and relationship: _________________________________________________

**MAIN COMPLAINT - SINCE WHEN?**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**RELEVANT HISTORY**

¿Where the client was born? ____________________________________________________________________

With whom he/she grew up? ____________________________________________________________________

It was an emotionally healthy environment? ______________________________________________________

Any complications during pregnancy? ___________________________________________________________

The child was born in how many weeks? _________________________________________________________

Type of delivery? C-Section: _____________________________________ Natural: ____________________________

How much he/she weighed and measured? ______________________________________________________

Did you have any complications at birth? _______________________________________________________

Did the child develop within expectations? _____________________________________________________

At what age did he/she walk? _____________________________________________________________

At what age he/she was toilet trained? ____________________________________________________________

At what age did he/she speak? ____________________________________________________________

Does the child has had a history of physical, emotional, sexual abuse, or have he/she had been exposed to domestic violence? ____________________________________________________________

With whom does the patient live? ____________________________________________________________

Does the child have a good relationship with the people he/she live in? ________________________________

How is the behavior at home? ____________________________________________________________

How is the behavior when he /she goes to shops, parks, birthdays, cinemas, etc.? ___________________________

____________________________________________________________

What school does he/she attends and in what grade he/she is attending and where is located? _______________

____________________________________________________________

How is his/her academic performance? (grades) ____________________________________________

How is his/her behavior in school? ____________________________________________________________

Does he/she have friends (at school, neighborhood)? ______________________________________________

Family history - Medical or mental conditions of your closest relatives? ____________________________

____________________________________________________________

Has your child had previous psychiatric or psychological evaluation or treatment? Has the child has been diagnosed with any mental health condition?

____________________________________________________________

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

____________________________________________________________

____________________________________________________________

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

____________________________________________________________

Describe any major accidents or hospitalizations: ____________________________________________

____________________________________________________________

Does the patient have any known allergies? ____ No ____ Yes, If yes identify: ________________________________

_______________________________________________________________________________________________

Does the child receive any type of therapy? ____________________________________________________________

_______________________________________________________________________________________________

What is the client/families' cultural and spiritual orientation? ______________________________________________

Does he/she follow instructions? _____________________________________________________________________

What are your child's strengths? _____________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Any valuable information about your child that you understand we should know?

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

***BEHAVIORAL HISTORY***

**Please check all that describe your child:**

___Cannot easily shift from one activity to another

___Bites nails

___Does not like to be touched

___Talkative

___Bad-tempered

___Clumsy

___Wet's bed

___Distractible/short attention span

___Shy

___Friendly

___Separation difficulties

___Difficulty sleeping

___Plays well with other

___Cooperative

___Attentive

___Poor memory

___Unpredictable

___Withdrawn

___Plays alone for reasonable amount of time

___Stubborn Still

___Overly sensitive emotionally

___Has nightmares

___Cries easily

___Easily frustrated

__Restless

___Quiet

___Impulsive/Impatient

___Easy going

___Poor eye contact

___Hyperactive

___Aggressive destructive

___Has temper tantrums

___Willing to try new activities

___Defiant

# PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

## ***EDUCATIONAL HISTORY***

School: ___________________________________ Grade: _______________

How is the child doing academically (or pre-academically)? ______________________________________

_____________________________________________________________________________________

Does the child receive special services? ___No ___Yes

If yes, describe: _________________________________________________________________________

_____________________________________________________________________________________

How does the child interact with others: (e.g., shy, aggressive, uncooperative, etc.)?

_____________________________________________________________________________________

Please provide any additional information that might be helpful in the evaluation or remediation of the child's needs:

_______________________________________________________________________

_____________________________________________________________________________________

Patient name: ________________________________________ Date: __________________

PATIENT/ RESPONSIBLE PARTY SIGNATURE: _______________________________________________

## PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

## 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 as a result of treatment.  I have read this form and certify that I understand its full content.

______________________________ ____________________________

Patient Name Date

___________________________________ ____________________________

PATIENT/ RESPONSIBLE PARTY SIGNATURE Date

## PLAY PALS THERAPY

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

## 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 |

**PLAY PALS THERAPY**

1428 Sunrise Plaza Drive Suite 3

Clermont, FL 34714

**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 un-notified absence, (i.e., cancellation not made 18 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 by 18 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.
This is why 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 cobrará antes de entrar a su próxima cita programada.

Gracias

**PRINT PATIENT NAME (NOMBRE DEL PACIENTE):** ______________________________

**PATIENT SIGNATURE (FIRMA DEL PACIENTE):** ______________________________

**DATE (FECHA):** ______________________

# ¡AVISO!

**No hay nada más importante que el bienestar de tus niños. El Cuidado Familiar, se enfoca en las necesidades del niño y de su contexto familiar. Las familias son vistas como participantes activos en la terapia de su hijo y no son excluidas del proceso.**

**Le agradecemos y solicitamos que todo niño que reciba terapias en nuestro centro NO PUEDE QUEDAR SOLO en ningún momento durante el proceso de recibir sus terapias. Los padres deben permanecer en la sala de espera.**
**Gracias.**

**La Administración se reserva el derecho de admisión.**

# ¡NOTICE!

**There is nothing more important than the well-being of your children. Family Care focuses on the needs of the child and their family context. Families are seen as active participants in their child's therapy and are not excluded from the process.**

**We thank you and request that every child who receives therapies at our center CANNOT STAY ALONE at any time during the process of receiving their therapies.**
**Parents should wait for their children in the waiting room.**
**Thank you.**
**The Management reserves the right of admission.**

________________________________

**Parent or Legal Guardian Sign**

1428 Sunrise Plaza Dr. Suites 2-3
Clermont, FL 34714
playpalstx@gmail.com

# Primary Care Physician Notification

Client Name: ______________________________ Date of Birth: ____________

**This client's Primary Care Physician is as follows:**

PCP Dr. Name: ______________________________

Mailing Address: ______________________________

City, State, Zip: ______________________________

Phone/Fax: ______________________________

Email address: ______________________________

☐ **I certify I do not have a PCP at this moment.**

***FOR NOTIFICATION PURPOSES ONLY -- DO NOT SEND RECORDS***

**Purpose of Release**:
This document serves as notification to the Primary Care Physician that counseling and/or behavior analysis services are being provided by Play Pals Therapy:

Intake date: ____________________

Clinician Name: Heidy Aponte

Clinician phone: 352-301-7535

**Acknowledgement:**

By signing below, I authorize Play Pals Therapy to release a copy of this document to the PCP named above. I further authorize exchange of confidential information between the PCP and Play Pals Therapy for the purpose of coordination of care. Contact information for Play Pals Therapy is as follows:

☐ 1428 Sunrise Plaza Dr. Suites 2-3 – Clermont, FL 34714 ☐ Email: playpalstx@gmail.com
☐ Fax 352-275-5024

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Play Pals Therapy.
- I understand that I may revoke this authorization in writing at any time; however, I cannot revoke authorization for action that has already been taken.
- A copy of this release shall be valid as the original.

**THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.**

______________________________ ____________________
Client/Legal Guardian Signature Date

1428 Sunrise Plaza Dr. Suites 2-3
Clermont, FL 34714
Ph: 352-301-7535 / Fax: 352-275-5024
playpalstx@gmail.com

# Release of Confidential Information to Other Organization

| I, | | hereby authorize: |
|---|---|---|
| | *(Print name of client or parent/guardian if minor child)* | |
| **PLAY PALS THERAPY, LLC - EMPLOYEE** | | |
| | | *PLAY PALS THERAPY, LLC* |

**To release confidential information consisting of** *(indicate the specific information that may be released, i.e., Psychiatric, Drug / Alcohol Records or Information, Medical Records or Information; Social History; Psychological Records or Information, Educational or School Records, etc…)* ***LIST SPECIFICALLY WHAT YOU WANT RELEASED:***

- 
- 

| **Regarding:** | ☐ | **Myself** | ☐ | **Minor Child** | | |
|---|---|---|---|---|---|---|
| (check one) | ☐ | **Child's Name:** | | ☐ | **Date of Birth:** | |

For the purpose of assisting with diagnosis, treatment or rehabilitation to:

| **Enter name & Address of Organization to whom the information is being released:** | |
|---|---|

I understand that only the above-specified information can be disclosed by the above-specified organization.

*This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987]*

This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature which is ***enter date*** _________________ or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken.

***(Signature of Client or Parent/Guardian, if minor)*** ***( Date )***

***(Signature of Witness)*** ***( Date )***

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer: ________________________________

Staff Name: Heidy Aponte ______________________ Degree/Credentials: P.H.D. ______________________

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Play Pals
Therapy

1428 Sunrise Plaza Dr. Suites 2-3
Clermont, FL 34714
Ph: 352-301-7535 / Fax: 352-275-5024
playpalstx@gmail.com

# Release of Confidential Information

| I, | hereby authorize: |
|---|---|
| | *(Print name of client or parent/guardian if minor child)* |
| **Name of Organization:** | |
| **Address of Organization:** | |

**To release confidential information consisting of** *(indicate the specific information that may be released, i.e. Psychiatric, Drug / Alcohol Records or Information, Medical Records or Information; Social History; Psychological Records or Information, Educational or School Records, etc…)* ***LIST SPECIFICALLY WHAT YOU WANT RELEASED:***

| | |
|---|---|
| Medication and Dosages | **X** |
| Medical Conditions | **X** |
| Significant Events | **X** |
| Mental Health Concerns | **X** |
| Other: | **MENTAL HEALTH DIAGNOSE** |

| | | | | | |
|---|---|---|---|---|---|
| **Regarding:** | ☐ | **Myself** | ☐ | **Minor Child** | |
| (check one) | ☐ | **Child's Name:** | | ☐ | **Date of Birth:** |

| | |
|---|---|
| **SEND FAX TO: 352-275-5024 / PLAY PALS THERAPY** | |
| Address: | ***SUNRISE PLAZA DRIVE SUITES 2-3 / CLERMONT, FL 34714*** |
| Attention: | RAMON MORALES |

I understand that only the above-specified information can be disclosed by the above-specified organization.

*This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987]*

This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature which is ***(enter date)*** ___________________ or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken.

***(Signature of Client or Parent/Guardian, if minor)*** ***( Date )***

***(Signature of Witness)*** ***( Date )***

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer: _________________________________

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**Confidential & Privileged Information for Professional Use Only**

Consent for Authorization to Release Information

**1428 Sunrise Plaza Dr. Suites 2-3**
**Clermont, FL 34714**
**playpalstx@gmail.com**

**Intake Consent**

Client Name: ___________________________________ Date of Birth: ____________________________

**Consent for Treatment and Treatment Location**: I am the legal guardian, or I am a competent adult and consent for the above-named client to participate in mental health assessment and treatment through PLAY PALS THERAPY at the following locations:

YES NO Client Home: __________________________________________________________________.

YES NO Client School: _________________________________________________________________.

YES NO Other: _______________________________________________________________________.

**I give permission and consent for the identify individuals or organizations to be part in the treatment of the above-named client. I acknowledge and understand that the identify persons will have access to confidential information for the intention of assessment and treatment.**

School: _________ teacher; __________ principal; ___________ staff; __________ guidance counselor
Family: _________ siblings; __________ grandparents; _______ foster parents; ________ step-parents

Referral Agency: _____________________________________________________________________

Other Providers: _____________________________________________________________________

**PRIVACY NOTICE:** I have received a copy of the **PLAY PALS THERAPY** brochure. All your information will be kept confidential from unauthorized personnel.

**PRIVACY EXCEPTIONS:** There are some situations or circumstances that are required to report confidential information about your child and family. Is the law to report any abuse or suspicious neglect of a minor, disabled or elderly person. The provider has the legal obligation to report any concern to the Department of Children and Families 1-800-962-2873. If during services, the counselor receives information that someone's life is in danger it is his/her legal duty to warn the threaten individual. If a counselor or **PLAY PALS THERAPY** documents are subpoenaed by Court Order, it is our responsibility to provide records or appear in court to answer questions about our client.

**FUNDING AUTHORIZATION:** I authorize _________________________ (funding agency or resource) to pay for services directly to **PLAY PALS THERAPY**. Is my obligation to be responsible for the charges that this funding source does not cover. I understand that any confidential information will need to be released to the funding agency or resource to process any claim and obtain reimbursement. I understand that I might refuse to sign this Authorization, but this action might not affect the ability to obtain treatment from **PLAY PALS THERAPY**.

**GRIVANCE PROCEDURE:** If you or family are not satisfying or agree with services or need to file a complaint or grievance, please call the Program Director, Ramón Morales, 352-301-7535.

This page has been explained to me and family. I understand that I can terminate services at any time, however, I cannot revoke consent for action that has already been taken. A copy of this release shall be valid as the original for a period of one year from the date of signing.

**THIS CONSENT EXPIRES AT THE TERMINATION OF TREATMENT OR 1 YEAR FROM THE DATE SIGNED**

________ (Initials) I received a copy of the "Notice of Privacy Practices" Please review it carefully.

________ (Initials) I received a copy of the Client Manual, which identifies right and responsibilities including who to contact for grievance and complaints.

________________________________ ___________ ___________________________ _____________
Parent/ Legal Guardian/Client Signature Date Primary Clinician Date