137 Monticello Avenue
Jersey City, NJ 07304
(T)201.966-7895
LM4SD@gmail.com
www.LM4SD.com

CLIENT INFORMATION & PARENT QUESTIONNAIRE

Please provide us with the following information so we can best serve your family.

Child's Full Name (Last, First):_____

Date of Birth:___/___/____ Age: ____ Sex: F M

Parent/Guardian Name: (Mr./Ms./Miss)_____

(Mr./Ms./Miss)_____

Marital Status: _____ Language(s) Spoken: _____

Sibling Names: _____

_____

Home Address:_____

_____

Primary Contact#: (_____)_____-_____
Please Circle: (Home/Work/Cell)
Email: _____

Secondary Contact: (____)_____-_____
Please Circle: (Home/Work/Cell)
Email: _____

Would you like to receive e-mails regarding upcoming workshops, programs, and special events? Yes ☐ No ☐

Person Responsible for Bill: _____

Date of Birth:_____ Address (If Different):_____

Phone Number (If Different): (___)_____-_____ Work Number: (___)_____-_____

Employer's Name: _____

Employer's Address: _____

How did you learn about Little Milestones for Small Discoveries?

_____

Reference's Name (If Any):

_____

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Child's Physician(s)

_____

Other Health Professionals, Agencies, or Medical Professionals working with your child?

_____

_____

_____

List current school or childcare provider:

_____

_____

List previous school/daycare experiences:

_____

_____

If your child receives services in school, please list them here (i.e. OT, PT, Speech):

_____

_____

TELL US MORE ABOUT YOUR CHILD

Please answer the following to the best of your knowledge:

Describe your child's developmental milestones (walking age, talking age, social skills):

_____

_____

_____

What are your child's strengths?

_____

_____

_____

What do you find difficult for your child to accomplish?

_____

_____

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Does your child have a hard time understanding or following directions?

_____

_____

Describe how your child gets along with other children

_____

_____

_____

YOUR CHILD'S LIKES/DISLIKES

Please answer the following to the best of your knowledge:

What are some things your child dislikes?

_____

_____

Please list your child's favorite play activities/toys?

_____

_____

What are your child's favorite foods?

_____

_____

Is your child a picky eater? Yes ☐ No ☐ If so, please explain below:

_____

_____

YOUR CHILD'S PAST MEDICAL HISTORY

Please answer the following to the best of your knowledge:

Has your child had any ear infections? Yes ☐ No ☐
If so, please indicate how often and how they were treated for it below:

_____

_____

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Does your child seem overly sensitive to noises, light, crowds, texture/touch, clothing, (etc.)
Yes ☐ No ☐ If so, please describe below:

_____

_____

_____

Does your child grind their teeth during the day/night? Yes ☐ No ☐ If so, please describe

_____

_____

Please describe any family history of health, mental, emotional, or learning difficulties:

_____

_____

_____

YOUR COMMENTS/CONCERNS

Please answer the following to the best of your knowledge:

Please describe any mealtime routines or concerns:

_____

_____

_____

_____

Please describe any bedtime routines or concerns:

_____

_____

_____

_____

Please describe any toileting routines or concerns:

_____

_____

_____

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Please share any other information that you feel will be helpful to us in working with your child/family:

_____

_____

_____

_____

_____

_____

INSURANCE INFORMATION:

Little Milestones for Small Discoveries, LLC , is an "Out of Network" Provider. Insurance reimbursement is dependent on your insurance plan and policies. Please be advised that a diagnosis may be needed for insurance consideration.

Has your child had any clinical evaluations (e.g. Developmental Pediatrician, Neurologist, Psychiatrist) ?
Yes ☐ No ☐ If so, when and where was it conducted?

_____

Please indicate whether your child received a clinical diagnosis? Yes ☐ No ☐

Diagnosis, if any: _____

Primary Insurance Name: _____

Member ID#: _____ Group ID#:_____

Policy Holder's Full Name: _____

Policy Holder's DOB: __/__/_____ SS#:_____-_____-_____

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Please indicate whether you have a Secondary Insurance: Yes ☐ No ☐

Secondary Insurance Name: _____

Policy Holder's Full Name: _____

Member ID#: _____ Group ID#:_____

Other: _____

FINANCIAL AGREEMENT:

Our practice is committed to providing the best treatment for our clients. Patients are responsible for all charges from treatments provided by Little Milestones for Small Discoveries, LLC. As a courtesy service to you, we will bill most insurance carriers directly. However, primary responsibility of the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your insurance card at the time of your next appointment.

MINORS:

The undersigned will agree to be responsible for payment of balance for services rendered to minors.

INSURANCE BILLING:

Please be aware that some or perhaps all of the services you receive may be non-covered services and are not considered reasonable and/or necessary under your insurance plan. Under this circumstance, you will be responsible for 100% of payment.

NO INSURANCE:

Payment for services is due at the time services are rendered.

CANCELLATION POLICY:

Your appointment time is especially reserved for you. If you need to cancel for any reason, you must allow our staff at least 24 hours advanced notice. **Failure to cancel 24 hours in advance will result in a nonrefundable, $50 service charge to your appointment.** In trying to do our best to serve you recommend that you always reschedule and confirm your appointments before leaving the office.

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PAYMENT AGREEMENT & CONSENT FOR EVALUATION & TREATMENT:

We will gladly discuss your proposed treatment and answer any questions related to your insurance and/or payment arrangements.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered.

I am also providing my consent for evaluation/treatment and/or participation in Little Milestones for Small Discoveries for:

_____

(Please Print Name of Child)

I have read all of the information on this sheet and I will notify you of any changes that might interfere with this financial agreement.

_____ _____

(Signature of Parent/Guardian) (Today's Date)

_____ _____

Print Parent/Guardian's Full Name (Today's Date)

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PERMISSION TO USE PHOTOGRAPH & VIDEOGRAPHY

Please initial on eof the following boxes to address photography and videography as a client of Little Milestones for Small Discoveries, LLC.

☐ I hereby consent Little Milestones for Small Discoveries, LLC, its representatives and its employees the permission to take photographs of my child: _____.
I also grant Little Milestones for Small Discoveries, LLC, the right to edit, use, and reuse photos and videos in print, on the internet, and all other forms of media and marketing. I agree that Little Milestones for Small Discoveries, LLC, may use such photographs/videos fo my child for therapeutic intervention purposes, learning purposes, publicity, illustration, advertising, and web design/content. I hereby release Little Milestones for Small Discoveries, LLC, and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

☐ I DO NOT give permission to Little Milestones for Small Discoveries LLC, its representatives and employees, the right to take photographs and/or videos of my child.

_____.

I have read and understand the above:

Signature of Parent/Guardian: _____

Parent/Guardian Name (Print): _____

Address of Parent/Guardian: _____

Child's Name (Print): _____

Date: _____

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CLASS REGISTRATION FORM

Which specialty CLASSES are you currently seeking for your child? (Please check all that apply)

- ☐ Zumba for Special Needs
- ☐ Sign Language and Speech
- ☐ Tummy Time
- ☐ Arts and Crafts
- ☐ Handwriting
- ☐ Tutoring

Which specialty SERVICES are you currently seeking for your child? (Please check all that apply)

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ ABA Therapy
- ☐ Play Therapy

Child's Full Name (Last, First):_____

Date of Birth:___/___/____ Age: ____ Sex: F M

Parent/Guardian Name: (Mr./Ms./Miss)_____

Home Address:_____

_____

Primary Contact#: (_____)_____-_____
Please Circle: (Home/Work/Cell)
Email: _____

Secondary Contact: (____)_____-_____
Please Circle: (Home/Work/Cell)
Email: _____