KIDSPACE Adaptive Play and Wellness
469 Buckland Road
South Windsor, 06074
Office: 860.432.9923
Fax: 860.432.7553
www.kidspaceadaptiveplay.com

Welcome!
Thank you for inviting us to participate in your family's healthcare. We hope that this relationship will be helpful as you journey towards improved health. Here at KIDSPACE, we have always functioned as a strong interdisciplinary team dedicated to providing your family with a comprehensive approach to health and wellness. With Jean Makar's experience as a licensed massage and CranioSacral therapist, Karen Peck's advanced training in CranioSacral Therapy and QiGong Massage and the addition of our new chiropractor, Dr. Faraneh, we're formalizing that offering to ensure that all our families, especially our breastfeeding dyads and our "kids" with special needs have accessible and holistic support. Dr. Meila Gruber continues to be available for naturopathic healthcare and holistic treatments for children with neurological and behavioral differences. What does this mean for you? That you may meet with one of us or all of us and have the benefit of our collective and individual experience.

Cost of visits are based on services provided:

Service	Cost
New Patient/Initial Consultation	$180
15 Minutes Adjustment, Soft Tissue or Craniosacral Therapy (CST)	$55
30 minutes Adjustment, Soft Tissue, CST &/or Kinesiotaping	$75
New Problem/Reevaluation & Treatment	$100
Tongue Tie Initial Evaluation	$180
Post-Revision Follow Up (exam & minimal treatment)	$55
Post-Revision Follow Up (exam and extensive treatment)	$75
Extensive Phone, Text or Email Consultation	$100/hr
Additional Reports	$50
Pharmacy or other product	Variable
Co-consult w/ Dr. Meila Gruber or Invited Guest	$75-$100
Additional Services	Practitioner's discretion

We have chosen not to participate in any insurance plans. Payment in cash or check is appreciated at the time of service. Upon request, we are able to provide invoices and reports for flex spending reimbursement. Please make checks payable to the individual you scheduled with (Karen Peck, Sharon A. Vallone DC, or Dr. Faraneh). Please speak with us about any financial concerns as soon as they arise.

To schedule an appointment, please call 860.432.9923

ABOUT YOUR CHILD **DATE OF INTAKE**________________

Full Name: ____Birthday (M/D/Y):__________Age: ___

Gender:_________Grade:______________School:____

Address: ____
(Street) (City) (State) (Postal Code)

Preferred Phone #: _______________ cell work home (circle one) Email:____________________

Emergency Contact:__________________________Relationship____________Phone___________

Family Status: M S W D Domestic Partnership Separated Grandparent Guardian Foster Other

Parent/Guardian 1: ______________ Preferred Contact:________________ Occupation:______

Parent/Guardian 2: ______________ Preferred Contact:________________ Occupation:______

Whom may we thank for referring you? ____

Who is your child's pediatrician?(MD or ND) ____

Who was your midwife or OB?____

REGARDING PREGNANCY AND LABOR

Your age when your baby was born?______How many pregnancies? ______Live births? _______

Any problems conceiving?__________Treatment?____

How was your pregnancy overall?____

During pregnancy were you on medication (over the counter/prescribed/recreational)?

____

During pregnancy did you smoke or consume any alcoholic beverages?______________________

Was there any pain or problems in pregnancy?____

Were you physically ill? (colds, flu, allergies, German measles, etc.)______________________

Was labor chemically induced?_______________Doctor assisted?__________________________

Approximately how long was labor?________Who was present?____________________________

Was a C-section performed?__________________Were forceps/vacuum used?_______________

Did doctor have hands on the infant?______What position were you in?____________________

Any time in NICU?______________Why?________________How long?________________________

What was your baby's gestational age?____Length and weight?_____Head circumference?____

Baby's APGARS:______1 min______5 min; Any problems at birth?_________________________

Did you breastfeed?______________Any problems?_____________________How long?________

Did you bottlefeed?______________What formula?______________________Any problems?____

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Did you see a lactation consultant in hospital?__________Who?________________________________
Did you see a lactation consultant privately?__________Who?_________________________________

REGARDING YOUR CHILD'S HEALTH

Please list in order of importance your chief concerns about your child
1.____ 2.____
3.____ 4.____
What are his/her current symptoms?____
Has he/she had any treatment for these symptoms?____
Has your child ever been hospitalized or had any surgeries?__________________________________
Is your child taking medication? (what, when, and why)______________________________________
____
Has he/she had any traumas (including birth), injuries or falls?
____
Has he/she ever been involved in a motor vehicle accident?___________________________________
Has he/she every had any broken bones or sprain injuries?____________________________________
Describe your child in you own words____
List any questions or concerns, past or present____
____
Has your child received standard vaccinations? List any reactions___________________________
____

Please describe your child's habits as good, fair or poor:
Sleeping___________________ Eating___________________ Listening___________________
Mood___________________ Physical Strength___________________

Does your child have any of the following?

__________Allergies __________Asthma __________Bedwetting
__________Bloody Noses __________Frequent Colds __________Constipation
__________Congestion __________Diarrhea __________Digestive Problems
__________Ear Problems __________Fatigue __________Flu
__________Headaches __________Hyperactivity __________Irritability
__________Learning Disorders __________Milk/Lactose Intolerance
__________Meningitis __________Nervousness _________Other
__________Poor posture __________Rashes __________Sleeping Disorders
__________Snoring/Apnea

Has your child had any extensive dental work, extractions or orthodonture?
____
Does your child have difficulty with food textures, chewing, or swallowing solids or liquids?
____

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Has your child had any of the following illnesses?

__________Measles __________German Measles ________Mumps
__________Pneumonia __________Scarlet Fever ________Chicken Pox
_________Cancer _________Rheumatic Fever _________Urinary Tract Infection
_________RSV _________Rotavirus _________Strep Throat
_________HIV/AIDS _________Tuberculosis _________Other Illnesses

SCHOOL AND SOCIAL HISTORY

Is your child home-schooled or enrolled in a traditional public, private, or special school?

____

Does your child experience stress from school work load?_________________________________

Academic performance?____

Peers?____

Athletic performance____

Other interests?____

Does your child have sensory sensitivities? Coordination Issues? Motor Development difficulties (fine or gross)____

____

FAMILY HISTORY

Please list immediate family members who have the following conditions:

Autoimmune disease:_____________________ Cancer:______________________
Diabetes: _____________________ Heart disease: ______________________
Stroke: _____________________ Allergies:_____________________
Alcoholism:______________________ Arthritis: ______________________
High Blood Pressure: _____________________ Headaches: _____________________
Fatigue:_____________________ Back Pains:______________________
Bursitis: ______________________ Other:_________________________

Please circle any of the following programs/services that would be of interest to you:

Support Groups Parent's Night Out Educational Workshops

Used Equipment Resources Birthday Parties Parental Resource Recommendations

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CONSENT FOR TREATMENT OF A MINOR
I, consent to the treatment/procedure rendered to my child or ward, __________________ , under general and specific instructions of my child's health care provider including but not limited to chiropractic, CranioSacral therapy, massage, sensory processing, or art therapy, as well as nutritional and whole health counseling. I have had the mechanisms and risks of chiropractic adjustments based on pediatric anatomy and physiology explained to my satisfaction and authorize said treatment on the above-named child understanding the risks and incidence of deleterious effect. I attest that I am the legal parent/guardian and that I am authorized to make healthcare decisions and consent to healthcare for this child.

____

Parent/Guardian Signature   Date

CONSENT TO PHOTOGRAPH
Photographs of your child help us see changes and help us teach other health care providers about caring for children with similar problems. Due to HIPAA regulations, I will ask permission from you to photograph your child and would like you to check beside each item that you give me consent to use your child's photo for:

Recording progress in the child's chart: ___Yes ___No _____Parent/Guardian Initial
For use in a professional presentation: ___Yes ___No _____Parent/Guardian Initial
For use in a professional publication: ___Yes ___No _____Parent/Guardian Initial

CONSENT TO SHARE INFORMATION WITH ALL PRACTITIONERS AT KIDSPACE
I have been informed that electronic medical records are shared amongst the practitioners at KIDSPACE, I consent to the sharing of my healthcare and education information with the other practitioners at the KIDSPACE facility whether co-treating or consulting.

____

Signature   Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR PERMISSION TO DISCUSS MEDICAL HISTORY/RECORDS
Patient's Name:____

CONSENT TO RELEASE MEDICAL RECORDS
I consent to the release of my medical records to:
Name:____
Address:____
____ Phone:_______________________
Parent/Guardian Signature:____
Date:________Relationship to patient, if signed by someone other than patient_____________

CONSENT TO DISCUSS MEDICAL HISTORY/RECORDS
I give permission to discuss my medical history/ records with:
Name:____
Address:____
____ Phone:_______________________
Parent/Guardian Signature:____
Date:________Relationship to patient, if signed by someone other than patient_____________

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PATIENT RESPONSIBILITIES

I agree to be financially responsible for all charges incurred at this office. I will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, a 15% interest charge will be added to the balance due. I am liable for any cost incurred by the office in collection efforts. **If you are unable to make your appointment, please provide 24 hour notice of cancellation. A cancellation fee will apply for appointments cancelled with less than 24 hour notice.**

____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, ______________________________________, hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access that information. I understand that if I have questions or complaints, I may contact: **Karen Peck CTRS, CST, QST**; **Sharon A. Vallone, DC, FICCP; or Faraneh Carnegie-Hargreaves, DC at 860.432.9923.**

I also understand that I am entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

____

Signature Date

____

Relationship to Patient, if signed by someone other than the patient.

____

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:

[ ] Patient declined to sign this written acknowledgement.

[ ] Other (specify):____

____

Name and title of employee Date

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will use and disclose your health information in order help you obtain payment for our services by allowing insurance companies to process insurance claims for services rendered to you by us or by other health care providers. Finally, we may disclose your health information for certain limited operational activities such as assessment, licensing, accreditation, and training of students.

Uses and disclosures based on your authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and disclosures not requiring your authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To government agencies for purposes of their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patients you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive a notice of our privacy practices.

A COPY OF THE COMPLETE NOTICE IS AVAILABLE UPON REQUEST.

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