2580 MONTESSOURI STREET, SUITE 101
LAS VEGAS, NV 89117
PHONE: (702) 686-3008 FAX: (702) 487-6355
Email: leanne_club4kids@coxbusiness.net

Patient Registration/Application (Aplicacion del Cliente)

Client Information	
Client Name: (Nombre del cliente)	**Date of Birth:** (Fecha de nacimiento)
Social Security #: (# de seguro social)	**Gender:** (Sexo)
Address: Direccion	
Home Phone: (Telefono de la casa)	**Cell Phone:** Telefono celular
Primary Care Physician Information (Informacion del Pediatra)	
Name (nombre):	**Facility (clinica):**
Phone (# telefonico):	**Fax (# de Fax):**
PARENT INFORMATION	
☐ Mother ☐ ther ☐ ther (Foster Parent, guardian, etc.)	
Name: (Nombre)	**Phone:** (Numero de telfono)
Address (if different from above): **Direccion (si es diferente a la de arriba)**	
Employer: Lugar de Empleo	**Work #:** Numero de trabajo
PARENT INFORMATION	
☐ Mother ☐ her ☐ ther (Foster Parent, guardian, etc.)	
Name: **(Nombre)**	**Phone:** **(Numero de telfono)**
Address (if different from above): **Direccion (si es diferente a la de arriba)**	
Employer: Lugar de Empleo	**Work #:** Numero de trabajo

INSURANCE INFORMATION		
Insurance: Aseguranza	**Group #:** # de grupo	**Policy #:** # de Poliza
Policy Holder: Asegurado	**Social Security:** # de seguro social del asegurado	
Copay: Tiene un copay?	**Deductible:** Tiene deducible?	
Secondary Insurance: Aseguranza secundaria?		

Please list any/all people that you are permitting Amy LaPres OTR & Leanne Wright Ltd to discuss and/or view your medical treatment with and their relationship to you. If no name is listed, information will only be discussed with the patient.

The information stated above, to the best of my knowledge, is correct and complete. I authorize Leanne Wright Ltd and or /their billing service to bill my insurance for any/all services rendered on the person listed above. I also allow my insurance to send payments directly ot Amy LaPres, OTR & Leanne Wright Ltd. I understand that I am responsible for any co-payments and/or deductibles not covered by my insurance. If for any reason a collection agency is required to collect outstanding funds, I understand that I am responsible for collection fees as well. I authorize Amy LaPres, OTR & Leanne Wright Ltd to release all necessary information to my insurance company. The below signature releases any/all medical records past or present to Leanne Wright Ltd from other providers.

Signature Relationship Date

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Client's Authorization for Emergency Medical Treatment
(Autorizacion para Trato Medico en una Emergencia)

Client's Name: ____________________________ **Date of Birth:** _________ **Phone:** ___________________
(Nombre del Cliente) (Fecha de Nacimiento) (numero telefónico)
Physician's Name: ___________________________________ **Medical Facility:** _______________________
(Nombre del pediatra) (Clinica medica)
Health Insurance: ________________________________ **Policy #:**__________________________________
(Aseguranza medica) (# de poliza)
Allergies to Medications: ____
(Alergias a medicaciones)
Current Medications: ____
(Medicaciones que esta tomando actualmente)

In the event of emergency, contact:
(En caso de emergencia, llame a:)

Name (Nombre)	**Relationship** (Relacion)	**Phone Number** (Numero Telefonico)

In the event emergency medical treatment aid/treatment is required due to illness or injury during the process of receiving serviced, or while being on the property of the agency, and the above cannot be reached, I authorize Leanne Wright Ltd to:
(En caso que el paciente necesite trato medico de emergencia a cause de enfermedad o golpe durante el proceso de recibir servicios aquí o mientras esta en la propiedad de la agencia y no se pueda localizar a las personas mencionadas arriba, yo autorizo que Leanne Wright Ltd):

1. **Secure and retain medical treatment and transportation if needed.** (consiga y retenga tratamiento medico y transporte si es necesario)
2. **Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment**. (le de a la agencia o individuo que esta dando el tratamiento de emergencia los records de el paciente si es requerido)

Consent Plan
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person above is unable to be reached.
(Esta autorización incluye rayos x, operaciones, hospitalizaciones, medicación y cualquier tratamiento que sea necesario para salvarle la vida al paciente según el doctor. Esto solo se usara si no podemos localizar a ninguna de las personas mencionadas arriba.)

Date: _________________ Consent Signature:____
(Fecha) (Firma de consentimiento)

Non-Consent Plan
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the even emergency treatment/aid is required, I wish the following procedure to take place:
(No doy mi consentimiento para trato medico de emergencia en el caso de un golpe o enfermedad durante el proceso de recibir servicios o estando en la propiedad de la agencia. En caso de una emergencia en donde se necesite tratamiento, deseo que lo próximo se haga)

____
____

Date: ________________ Non- Consent Signature: ____

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HEALTH HISTORY (Historia de Salud)

Please indicate current or past problems in the following areas (Por favor indique problemas actuales o pasados en las areas siguientes)		
Vision (vista) Yes No	**Hearing (audicion)** Yes No	**Elimination (eliminacion)** Yes No
Communication (Comunicacion) Yes No	**Heart (corazon)** Yes No	**Breathing** Yes No
Digestion (Digestion) Yes No	**Sensory Integration (sensacion)** Yes No	**Circulation (circulacion)** Yes No
Emotional (emocional) Yes No	**Behavioral (comportamiento)** Yes No	**Pain (dolor)** Yes No
Bone (huesos) Yes No	**Muscles (musculos)** Yes No	**Thinking** Yes No
Allergies (alergias) Yes No	**Contagious Diseases (enfermedades contagiosas)** Yes No	**Other: Otro:**

BIRTH HISTORY

Was your child born premature or full term? ____________________ **If premature, how early?** ____________________________
(su hijo nacio a tiempo o prematuro?) (Si nacio premature, a los cuantos meses?)

Has your child passed the newborn hearing screening? **Yes** **No**
(Ha pasado el chequeo de los oídos de recién nacidos?)

How many days was your child in the hospital before being released? ____________________
(Cuantos dias paso su hijo en el hospital antes de ir a casa?)

List any complications with birth (complicaciones con el parto**):** ____________________

____

Describe any hospitalizations, illnesses, or injuries (describa hospitalizaciones, enfermedades o lesiones): ____________________

____

____

Diagnosis: ____________________ **Age diagnosed:** ____________________
(Diagnóstico) (Edad que lo diagnosticaron)

Current Medications (Medicaciones acutales):

____

List any doctor or specialist your child has seen (other than a pediatrician)
(mencione cualquier doctor o especialista que su hijo ha visto, aparte de su pediatra)

____

____

Languages spoken at home: ____________________
(Lenguajes que se hablan en la casa)

Equipment (i.e. Wheelchairs, walkers, etc.): ____________________
(equipo: por ejemplo silla de ruedas, andadores etc.)

Please comment on your child's balance and mobility (i.e. good balance, stumbles, falls, able to walk independently)
(Por favor comente en los niveles actuales de balance y movilidad (i.e. buen balance, se cae, tropieza, puede caminar solo?)

____

____

____

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CURRENT LEVELS OF FUNCTIONING

Please comment on your child's current level of functioning in the following areas:

BATHING (like/don't like, washing hair, can child reach all body parts and wash, etc):
BAÑARSE (Le gusta o no, puede bañarse solo? Puede lavarse el pelo solo?)

GROOMING (hair, teeth, having nails trimmed, etc.):
ARREGLARSE (puede peinarse? puedo lavarse los dientes? Cortarse la uñas?)

FEEDING (can they feed self, drink out of cup, regular or sippy, utensil use, spillage, food issues, oral motor, hold food in mouth, etc):
COMIDA (puede comer solo? Toma de un vaso? Usa tenedores etc., no le gusta alguna comida? Le cuesta mantener comida en la boca?)

DRESSING UPPER BODY (put shirt on, buttons, snaps, zippers, coat, etc):
Vestirse extremidad de arriba (puede ponerse una camisa? Botones? Cierre? Abrigo?)

DRESSING LOWER BODY (put pants on, pull pants up, fasteners, etc):
Vestirse extremidad baja (puede ponerse pantalones? Subir el zipper?)

TOILETING (diapered/pullups, accidents at night, difficulty wiping, etc.):
Inodoro/baño (pañales o pull-ups?, accidentes en la noche? Dificultad limpiándose?, etc)

SOCIAL (behaviors, leisure interest, relationship-family structure, support systems, companion, animals, fears/concerns, etc.)
Social (comportamiento, intereses, relacion con familia, animals, miedos/temores)

UNDERSTANDING SPOKEN LANGUAGE (follows directions, understands questions):
Entendiendo Lenguaje Hablado (entiende preguntas? Sigue instrucciones?)

EXPRESSIVE LANGUAGE (use of words, sentences or gestures to communicate):
Lenguaje Expresivo (uso de las palabras, frases o gestos para comunicarse):

SPEECH (are the words clear, do most people understand the words):
Habla/Lenguaje (las palabras son claras, puede la gente entender las palabras?)

SOCIAL/PRAGMATICS (responds to greetings, can hold a conversation, says appropriate things for the situation):
(Social/Pragmatica) (responde a los saludos, puede sostener una conversacion, dice cosas apropiadas para la situacion):

GOALS (e.g. Why do you want to receive services? What would you like to accomplish?)
Metas (Por que quiere recibir servicios? Que quiere alcanzar?)

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Single Outpatient Therapy Provider

Nevada Medicaid and Tricare/Triwest do not authorize Occupational Therapy services in more than one outpatient location at a time, Physical Therapy services in more than one outpatient location at a time, and Speech Therapy services in more than one outpatient location at a time.

(Las aseguranzas Nevada Medicaid y Tricare Triwest no autorizan que un paciente reciba terapia ocupacional en mas de una clínica a la vez, terapia física en mas de una clínica a la vez, y terapia del habla en mas de una clínica a la vez.)

Are you currently receiving Occupational Therapy services at another location? (Esta actualmente recibiendo servicios de terapia ocupacional en otra clínica?) **If yes, please explain** (Si si, por favor explique):	Yes	No
Are you currently receiving Physical Therapy services at another location? (Esta actualmente recibiendo servicios de terapia física en otra clínica?) **If yes, please explain** (Si si, por favor explique):	Yes	No
Are you currently receiving Speech Therapy services at another location? (Esta actualmente recibiendo servicios de terapia del habla en otra clínica?) **If yes, please explain** (Si si, por favor explique):	Yes	No

I, ____________________, the parent/legal guardian of ________________________, hereby state that as of _____________(date) my child will only receive (circle all applicable) OT / SLP / services from A Clubhouse For Kids. I authorize A Clubhouse For Kids to be the only outpatient therapy services provider to bill for these services from today forward. I have read this document, understood this document and agree to this document. I know that I can change the terms to this document in writing at any time.

Yo, __________________, el padre/ guardian de ______________________, aseguro que desde ____________ (fecha) mi hijo solo recibirá servicios de (circule lo que aplica) OT/ SLP/PT en A Clubhouse For Kids. Yo autorizo que A Clubhouse For Kids sea la única clínica que pida pagos para este tipo de servicios. Yo he leído este documento, lo he entendido y estoy de acuerdo con este documento.

Signature and printed name of client/client's parent/legal guardian — **Date**
(Firma y nombre del padre/representante legal) — Fecha

Signature and printed name of witness — **Date**
(Firma y nombre de el testigo) — Fecha