HELPING HANDS
PEDIATRIC THERAPY SERVICES

Date: _____

Last Name:	**First Name & Initial:**	**Date of Birth:**	**Male Female**
Address:			
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Social Security Number:			

Parent's First and Last Name:	Parent's Social Security Number:
Address:	Date of Birth:
City/State/Zip:	

Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Employer	Employer Phone	Employer Address

Parent's First and Last Name:	Parent's Social Security Number:
Address:	Date of Birth:
City/State/Zip:	

Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Employer	Employer Phone	Employer Address

Primary Insurance Company NAME and PHONE NUMBER:

Primary Policy Number:	Primary Group Number:	Primary Subscriber Name:

Secondary Insurance Company NAME and PHONE NUMBER:

Secondary Policy Number:	Secondary Group Number:	Secondary Subscriber Name:

Emergency Contact Name and Relation to Patient:	Phone Number:

AUTHORIZATION TO PAY BENEFITS TO HELPING HANDS, INC.: I hereby authorize payment directly to Helping Hands, Inc., otherwise payable to me for services rendered, realizing I am responsible to pay non-covered services. I also realize that I am responsible for any other cost incurred while collecting my outstanding balance(s).

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Helping Hands, Inc. to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____ _____

Signature (Legal Guardian/Parent, if minor) Date

Client Name: _____ Date of Birth: _____

Helping Hands, Inc. · 2049 Richmond Highway · Stafford, VA · 22554 · Phone: 540-657-1423 · Fax: 540-657-1424

HELPING HANDS, INC.

HIPAA/ RELEASE OF INFORMATION FORM

Patient's Full Name **Patient's Date of Birth**

I, the parent, or guardian, hereby authorize the use or disclosure of protected health information (PHI) about my child as indicated below:

1. The following person/facility is authorized to use or disclose PHI about my child:
   _____HELPING HANDS, INC._____
2. The following person (or class of persons) may receive protected health information about my child, additional persons may be listed on the back of this form:

Name	**Relationship to patient**
Name	**Relationship to patient**
Name	**Relationship to patient**

I, the parent/guardian, hereby consent to receive notifications from Helping Hands, Inc., by the methods of communication indicated below. I am aware such notifications may include my child's PHI. I agree to assume all responsibility for informing Helping Hands, Inc., in writing of any changes to any of the methods of communication listed below and I may revoke this authorization of communication by notifying Helping Hands, Inc., in writing. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations. This authorization expires 1 (one) year after the patient's last visit to our office. Please list **ALL** email addresses and phone numbers you would like for use in communication, communication methods **NOT** listed will not be used.

Email: _____
Phone/Text: _____
Phone/Voicemail: _____

I have been provided access to HIPAA Notice of Privacy Practice and advised of my rights under HIPAA. ***Initial*** **_____**

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility will provide you with one original copy of the initial evaluation and any re-evaluation reports; to be mailed or emailed 2-4 weeks after the initial evaluation. You may request additional copies, fees apply. (See page 6 of the patient intake)

_____ _____ _____

Signature of Guardian or Personal Representative of Patient **Date** **Relationship to Patient**

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Helping Hands Policies

PLEASE READ CAREFULLY BEFORE SIGNING

1. NO patient will be seen without a current physician's order. (No exceptions.)
2. **Cancellation and Attendance Policy must be followed**: Please refer to separate document.
3. **Your child's therapy is a serious commitment between you and his/her therapist.** Helping Hands, Inc. requires consistent attendance to maximize your child's progress. We reserve the right to terminate therapy if appointments are not attended as scheduled, and discharge if NO therapeutic progress has been made in 3 months.
4. **If Helping Hands, Inc. DOES NOT have a contract with your insurance company**, payment is due at the time services are rendered. All documentation needed for you to file a claim with your insurance company will be provided to you upon request.
5. **If Helping Hands, Inc. DOES have a contract with your insurance company**, we will submit your claim to your insurance company. If policy information is not provided @ the time of service, our office will only back bill up to 60 days from the date policy information is provided. *It is your responsibility to know what your health care plan will cover and to abide by its rules regarding services in our office as well as referrals, preauthorization's, etc. If you have questions about what your health care plan will and will not cover, you need to contact your plan directly. You are responsible for making your co-payment/deductible at every visit.* Please note that it takes **at least one week** to generate a referral or preauthorization. You are responsible for notifying us of any changes regarding your insurance coverage. We are not responsible for obtaining preauthorization for therapy services if we are not informed of current insurance coverage, and you are responsible for any non-covered and/or denied charges incurred on your child's behalf.
6. If you are a Tricare Prime member, you are responsible for ensuring that all required referrals are submitted to Tricare by your primary care manager (PCM) and corresponding authorization is received by our office. No services will be rendered without prior authorization. The services listed on the authorization will be the ONLY services rendered. You may not request additional services be rendered as they will not be covered by Tricare.
7. You will be billed a $25.00* fee for each check returned by the bank.
8. If an account 60 days or more delinquent is taken to court, you are responsible for all collection and/or attorney fees incurred by Helping Hands, Inc.
9. All co-payments/deductible payments must be made prior to any services being rendered.
10. Once services are rendered, private pay rate (fees) are non-refundable. We are a fee for service provider.

**Our office offers automatic payment plan service for co-payments and deductibles. If you are interested in this service, please contact our office for enrollment information.

I authorize HELPING HANDS, INC. to apply for benefits on my behalf for covered services rendered. I request payment to be made directly to HELPING HANDS, INC. I certify that the information I have provided regarding my insurance coverage is correct, and further authorize the release of any necessary information, including medical information for any related claim, to Helping Hands, Inc.* billing agent and/or my insurance carrier. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing at any time by either me or my insurance carrier.

I have read the above policy and agree to abide by it.

_____ _____

Parent's Name – please print Date

_____

Parent's Signature

**Fees subject to change*

HELPING HANDS, INC.
ATTENDANCE/CANCELLATION POLICY – *Effective August 2024*

- **All cancellations must be made at least 24 hours prior to your appointment, to avoid a No Show/Late Cancel fee.** For each appointment, a full hour of staff time and treatment space are reserved for your child, therefore proper notice allows us adequate time to potentially fill that time slot with another patient. Please call/text to cancel any appointment-we do not accept emails to our website to cancel an appointment. Our therapists are not responsible for communicating their clients' cancellations, scheduling conflicts, and vacation info to the front office. _____ ***Initial***

- **If an appointment is NOT cancelled with at least a 24-hour notice, *for ANY reason,* the patient's account will automatically be assessed with a $50.00 Late Cancel fee. If parents/guardians reschedule their child's appointment, then the Late Cancel fee will be reduced to $25.00** ***WE DO NOT WAIVE THIS FEE*** _____ ***Initial***

- **Appointments not attended by the patient, with no notification to the front office, are subject to a $50.00 No Show fee.** ***WE DO NOT WAIVE THIS FEE*** _____***Initial***

- **All fees related to attendance will be billed directly to you. These fees must be paid before or at the time of your child's next appointment or the child will NOT be seen.** Neither your insurance company nor your flexible spending account will cover these fees. _____ ***Initial***

- **Please be aware that we will do everything possible to match the therapist and family schedule, however a reschedule may occur with any therapist in our office at any available times.** For example, if your regular appointment is at 5PM, there is NO guarantee that when rescheduling you will be able to have the same time and therapist. _____ ***Initial***

- **Our office will make every effort to provide therapy to your child in circumstances where clients are late checking in**. If you arrive late to your child's appointment, the session will conclude at its regularly scheduled end time; however, if you arrive more than 15 minutes late, your child will not be seen, and you will be required to reschedule the appointment or pay the NO SHOW fee of $50.00**.** _____ ***Initial***

- **Our office reserves the right to remove from the schedule a client who is not regularly attending therapy or a client who continuously arrives late:**
  - We allow **TWO** missed appointments per treatment plan that **DO NOT** need to be made up, any cancelation after is **REQUIRED** to be rescheduled.
  - Two No Show/Late Cancels of your child's regularly scheduled appointment (within the duration of your treatment plan) that are not rescheduled will result in your child being removed from the schedule effective immediately. If there are extenuating circumstances preventing you from bringing your child to their appointment, please contact the front office immediately to discuss and avoid removal from the schedule. _____ ***Initial***
  - **Reschedules** must be made within **3 weeks of the missed appointment**. After the 3-week window the **Late Cancel** fee will be applied to the account. _____*Initial*

- **We require that an adult be ON SITE during the full length of their child's therapy session. If you are not able to remain on the premises, we require you to reschedule the appointment.** _____ ***Initial***

By signing below, I acknowledge receipt of this attendance & cancellation policy and agree to the terms stipulated above.

_____ _____

Signature of Parent/Guardian Date

HELPING HANDS, INC.
WEATHER POLICY

We DO NOT operate in coordination with public/private school systems, local government office closings, or federal government closings. **If our office is open, regardless of the weather conditions, parents/guardians are still subject to cancellation/no-show fees.**

During times of inclement weather, any closings and/or delayed opening information will be posted on our website (www.hhitherapy.com). A message will also be available by calling our office (540-657-1423). Should our office close early due to inclement weather, parents will be called immediately to be notified.

SICK POLICY

Your child must be free of all: fever, diarrhea and vomiting for a 24-hour period prior to receiving therapy. We will take temperatures, sanitize hands, and ask questions regarding symptoms and care of others with COVID, at the window each visit.

The updated list of symptoms we will be monitoring includes the following. Please familiarize yourself with them as if your child has any of the following, they may be asked to leave. We are aware that they overlap with many other things such as allergies and the common cold, however, we need to respect the needs of those with more fragile systems.

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Our office has 24-hour voicemail. You may call at any time during the day or night to notify Helping Hands, Inc, that you need to cancel your child's session. This is a Helping Hands, Inc. policy. All questions regarding this policy should be directed to our practice director/owner, Lisa Worcester, at 540-657-1423.

By signing below, I acknowledge receipt of this attendance & cancellation policy and agree to the terms stipulated above.

_____ _____

Parent's Signature Date

HELPING HANDS, INC.
NOTIFICATION OF FEES

Our office offers the following private pay rates for therapy should Helping Hands not contract with your insurance company: (Once services are rendered this fee is non-refundable)

Occupational Therapy Evaluation: $425.00

Occupational Therapy, 50 minutes: $125.00

Speech Therapy Evaluation: $325.00

Speech Therapy, 30 minutes: $62.50

Requested Medical Records are provided once to client/parent for free. Any copies requested thereafter are subject to a fee and must be rendered prior to release of requested records. Medical Records Policy may be provided to client/parent upon request for review.

The following services are not billable with ANY insurance, and you will be required to pay for the following if requested (All requests MUST be made at the front desk; any request(s) made directly to the therapist will NOT be honored):

(Speech & Occupational Therapy are two separate incidents)
Completion of forms: $5.00 per form
School recommendations/Medical Necessity letter: $40.00 per request
Meeting attendance: $100.00 per meeting
Observation at outside location: $100.00 per observation

I, _____, have read and understand the Helping Hands, Inc. Financial Policy. I understand that due to the specialization of the services provided by Helping Hands, Inc., I will be responsible for services not covered by my insurance carrier including, but not limited to, co-pays, deductibles, and non-covered services.

_____ _____
Parent's Name – please print Date

**Fees subject to change*

HELPING HANDS, INC.
MEDICAID MCO POLICY

A managed care organization (MCO) is a health care provider or a group or organization of medical service providers who offers managed care health plans. These MCOs agree to provide most Medicaid benefits to people in exchange for a monthly payment from the state. Private insurance companies may offer health plans for Medicaid recipients and these plans are considered Medicaid MCOs.

Our office participates with the following Medicaid MCOs:

- Sentara Health

Helping Hands, Inc. **DOES NOT** participate with fee-for-service Medicaid or any other Medicaid MCO.

If your Medicaid MCO changes from Virginia Premier or Virginia Premier Elite Plus during the time in which your child is receiving therapy services to a coverage we do not participate in (such as fee-for-service Medicaid), you acknowledge that you are responsible for the balance owed for services rendered. It is the patients'/parents' responsibility to stay informed as to the status of your coverage, and any changes to your coverage that may occur.

I, _____, have read and understand that Helping Hands, Inc. does not participate with fee-for-service Medicaid.

I, _____, have read and understand the Helping Hands, Inc. Medicaid MCO Policy, and that I will be responsible for any balance owed for services rendered should my child's Medicaid MCO coverage change to a non-participating MCO or fee-for-service Medicaid.

_____
Parent's Signature

_____
Date

HELPING HANDS, INC.
INFORMED CONSENT FOR SERVICE FEES

Evaluation: A typical Occupational Therapy evaluation consists of a standardized assessment of fine and gross motor skills, visual motor coordination, bilateral coordination, and a sensory integration evaluation. We assess all patients in all areas and do not segment out our assessments regardless of insurance coverage. Any services deemed excluded from your insurance plan may be billed to the patient.

Initial _____

Treatment: I voluntarily consent to treatment/services that are deemed necessary by my referring physician and my occupational therapist. I understand that it is this practice's intent to educate me on every process during my treatment program. I understand that therapy will be rendered for set duration and frequency leading to discharge. I understand that "hands-on" manual or exercise techniques may be used to retrain, recruit, and restore improved postural alignment with treatment, and that if I do not completely understand the process of my treatment, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how she/he is trying to achieve them. I also realize that no guarantees have been made to me as to the results of these services at Helping Hands, Inc. Helping Hands, Inc. will assign patients to a "Primary Therapist" but patients may be seen by any of our therapists as we are a rehabilitative facility and all therapists are licensed and trained to work with all patients.

Initial _____

Observation: All services provided at Helping Hands, Inc. may be recorded or observed. These observations are restricted to individuals who are associated with Helping Hands, Inc., and have completed HIPAA training. Non-identifying information may be used for administrative purposes.

Initial _____

Photos & Videos: Pictures and videos may be made of activities within the practice. These pictures may be used for educational purposes, in Helping Hands, Inc. brochures/presentations, on the Helping Hands, Inc. website, and/or in association with clinic media coverage. Please indicate below your intent to grant permission to use photos of your child as specified above:

Yes _____ No _____

Helping Hands, Inc. will respect the right of privacy of its clients and will hold all recorded sessions and information with strict confidence and will use this information only in rendering of professional services or educational instruction. The contents of your sessions will not be revealed to any person or agency except under the following circumstances:

1. If you, or a legal guardian/parent, give written permission to release the information.
2. If you or your child reveals information which, in your clinician's judgment, indicates that you or your child intends to harm self or someone else.
3. If you or your child reveal information that indicates the existence of past or present abuse of a child, elderly, or disabled adult, as required by Virginia law.
4. If an appropriate court order or subpoena is received.
5. If you or your child is involved in a medical emergency, information may be given to medical personnel.

I, the undersigned, am the parent/legal guardian of the client named below. I have read and understand the above and consent to services for my child and/or family at Helping Hands, Inc.

_____
Printed Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date

HELPING HANDS, INC.
For TRICARE Patients ONLY

Humana Military, TRICARE EAST, requires our facility to have a signed written statement from the parent/guardian before they will cover the cost of therapy for patients aged 3-21 to ensure the following:

- The patient does not have an active IEP that provides related OT or ST services during treatment with our facility
- The patient is not receiving OT or ST from any other publicly funded agency

If your child ***DOES*** currently have one or both above-mentioned services TRICARE EAST may not cover the cost of therapy. Please ask to speak with Samantha, in our billing department, to discuss how to proceed with coverage for therapy. DO NOT SIGN THIS FORM.

If your child ***DOES NOT*** receive any of the above-mentioned services, please sign this form as your written statement to TRICARE EAST.

Patients Name: _____
Date of birth: _____

Parent/Guardian Signature: _____
Date: _____

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Patient's Right's & Responsibilities

Patient's Right's

- Access to copies of his/her medical records by written request.
- Quality services appropriate to your condition and delivered on time.
- Any medically necessary treatment.
- Reasonable access to care.
- To be treated with dignity, respect, and concern.
- Complete confidentiality of all medical and financial records.
- Information about your condition as it relates to diagnostic tests, treatment plans and other procedures.
- The ability to change therapists at any time or to request a second opinion within or outside this practice.
- Visual privacy.
- Refusal of treatment or therapy and information regarding the consequences of such a decision.
- Expression of your concerns, complaints, and grievances.
- The right to an itemized statement of billed charges upon request.

Patient's Responsibilities

- Please try to keep all scheduled appointments.
- Please notify us when you are unable to keep a scheduled appointment.
- Feel free to ask questions when you need more information or do not understand.
- Take responsibility for your health. Use this practice in an advisory role when making healthcare decisions.
- Be informed regarding your insurance plan, treatment coverage and benefit rules.
- Obtain any necessary referrals from your primary care physician prior to your appointment.
- Treat our staff with courtesy and dignity.
- Our goal is to provide the best possible care. Please help us in our efforts by reviewing the information in this packet. We encourage you to discuss any concerns or ask any questions when you are in our offices.

Additionally, you may contact our offices about your questions and concerns at any time. Simply call the office and ask to speak to a manager or supervisor. We thank you for choosing our office for your therapy needs.

_____ _____

Signature of Parent/Legal Guardian Date:

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Developmental and Medical History for Occupational Therapy

Child's name (please print) Informant's name and relation (please print)

Briefly describe why you are pursuing an occupational therapy evaluation for your child:

_____

_____

Please circle the answers which best describe your child. Please add any remarks or comments that you feel may be helpful, including your child's strengths. This information is vital to our evaluation process. Your observations give us details about day-to-day life, and so, help us to interpret our test findings with greater accuracy. Thank you for your time.

BEFORE BIRTH		
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations, or any other medical difficulties?	YES NO	Remarks:
2. Were there any drugs, medications, alcohol, or cigarettes used during pregnancy?	YES NO	Remarks:
3. If adopted, provide the date and age when the child arrived at your home. Please specify any known details of care before adoption.	Date _____ Age_____	Remarks
DELIVERY		
1. Was the delivery premature?	YES NO	Remarks:
2. Was medication given to induce labor or given during labor? Please specify.	YES NO	Remarks:
3. Was the labor abnormal? (ie. Prolonged, short, etc.?) Please specify.	YES NO	Remarks:
4. Was it an unusual delivery? (ie. Breech, Caesarean, forceps, etc.) Please specify.	YES NO	Remarks:
5. What was the baby's gestational age (in weeks) and birth weight?	AGE: _____ (weeks) WEIGHT: _____ lbs. &_____ oz.	Remarks:
BIRTH		
1. Was the baby alert with normal muscle tone and color at birth?	YES NO	Remarks:
2. Were there medical complications at birth affecting the heart, lungs, kidney, or digestive organs? Please explain.	YES NO	Remarks:
3. Were there any congenital defects affecting the limbs, face, nerves, and/or other body parts? Please explain.	YES NO	Remarks:
4. Were there complications such as cyanosis, jaundice, or limpness? Please specify.	YES NO	Remarks:
5. Was there a need for oxygen, transfusions, IV, or tube feedings?	YES NO	Remarks:
6. Did the baby spend extra time at the hospital or time in a special nursery?	YES NO	Remarks:
7. Was the baby bottle or breast-fed? Please circle.	BOTTLE BREAST-FED	Remarks:
8. Were there any feeding complications? Please specify.	YES NO	Remarks:

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MEDICAL HISTORY SINCE NEWBORN PERIOD		
1. Are your child's immunizations up to date for the following: a. Measles, Mumps, & Rubella b. Chicken Pox c. Diphtheria, Pertussis, & Tetanus d. Polio e. Hepatitis B	 YES NO YES NO YES NO YES NO YES NO	Remarks:
2. Describe any significant adverse reaction to vaccines.		Remarks:
3. Circle any serious illnesses (s)he has had and give dates and current status. a. Meningitis b. High Fevers c. Scarlet Fever d. Diabetes e. Seizures (dates, how often, type?) f. Respiratory, stomach, kidney, liver, or heart problems g. Any allergies (please specify) h. Tuberculosis i. Polio j. Physical Injuries k. Malnutrition l. Frequent Ear Infections/Tubes m. Surgeries n. Others, please list:	Dates: a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ l. _____ m. _____ n. _____	Remarks:
4. Has your child had vision and hearing exams? Circle and list dates, by whom, and results. a. Vision b. Hearing	 Dates: a. _____ b. _____	Remarks:
5. Is your child currently on medication? Please give names and reasons.	YES NO	Names and Reasons:

DEVELOPMENTAL HISTORY

At what ages did your child meet these motor milestones? Please note those that were skipped or not yet achieved.	Age:	Comments/Clarifications:
1. Roll over both ways	1. _____	
2. Sit independently	2. _____	
3. Crawl on hands and knees	3. _____	
4. Cruise around furniture	4. _____	
5. Walk independently	5. _____	
6. Speak first word	6. _____	
7. Drink from a cup without a lid independently	7. _____	CIRCLE: Left-Handed / Right-Handed
8. Use a spoon independently	8. _____	
9. Demonstrate hand preference	9. _____	
10. Put on shirt independently	10. _____	
11. Button independently	11. _____	
12. Dress independently	12. _____	
13. Ride a tricycle	13. _____	
14. Ride a bicycle without training wheels	14. _____	
15. Pump a swing	15. _____	
16. Learn to tie shoelaces	16. _____	

Describe your child as an infant:			Comments/Clarifications:
1. Good, non-demanding	YES	NO	
2. Cried a lot, fussy, irritable	YES	NO	
3. Was alert	YES	NO	
4. Was active	YES	NO	
5. Was passive	YES	NO	
6. Liked being held	YES	NO	
7. Liked being rocked	YES	NO	
8. Was tense when held	YES	NO	
9. Was floppy when held	YES	NO	
10. Slept through the night easily	YES	NO	
11. Had irregular sleep patterns	YES	NO	

Describe your child at present:			Comments/Clarifications:
1. Mostly quiet	YES	NO	
2. Talks constantly	YES	NO	
3. Overly active	YES	NO	
4. Tires easily	YES	NO	
5. Impulsive	YES	NO	
6. Restless	YES	NO	
7. Stubborn	YES	NO	
8. Resistant to changes	YES	NO	
9. Over-reacts	YES	NO	
10. Fights frequently	YES	NO	
11. Often happy	YES	NO	
12. Frequently has temper tantrums	YES	NO	
13. Falls often	YES	NO	
14. Clumsy	YES	NO	
15. Has difficulty separating from primary caregiver	YES	NO	
16. Wanders off without caution	YES	NO	
17. Has nervous habits or tics (please specify)	YES	NO	
18. Wets the bed	YES	NO	
19. Poor attention span	YES	NO	
20. Easily frustrated	YES	NO	
21. Has unusual fears (describe)	YES	NO	
22. Rocks self during activities (describe)	YES	NO	
23. Bangs head on purpose	YES	NO	
24. Has difficulty learning new tasks (ie. Bike riding, drawing/writing, throwing a ball, etc.)	YES	NO	

ADDITIONAL INFORMATION

What are your greatest concerns for your child relative to his/her developmental and occupational therapy?

_____

_____

_____

_____

What are your child's strengths?

_____

_____

_____

_____

Please comment on your child's school behavior:

_____

_____

_____

_____

Does your child behave differently at home than in other settings? Please describe.

_____

_____

_____

_____

What else would you like Helping Hands to know about your child?

_____

_____

_____

_____

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ADDITIONAL INFORMATION

Has your child had any of the following examinations?
If so, please give the approximate date and the examining person's name and address:

	Date	By Whom	Diagnosis (DX)
Most recent physical examination			
Neurology			
Psychiatry			
Psychology			
Education			
Speech and Hearing			
Other special examinations			

(Please provide a copy of all reports)

Does your child have a current IEP/504 Plan, at school for Occupational Therapy? Yes _____ or No_____

If your child receives related services through an IEP/504 Plan, please be sure to provide us a copy for our records.

Additional information that would help us to better understand your child:

_____
_____
_____
_____
_____

Do not leave any blank spaces. If the question/item does not pertain to your child, please indicate "N/A" (Not Applicable).