6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

Pediatric Patient Information

Patient name: _____ Date: _____

Date of Birth: _____ Age:_____ □ Female □ Male

Parental Status: □Biological □Adoptive □Foster □Legal Guardian

Parent/Guardian: _____ Contact:_____
Name DOB Primary# Secondary#

_____ Contact:_____
Name DOB Primary# Secondary#

E-mail Address: _____ _____

With whom does the child reside?_____

Siblings' names and ages:_____

Address: _____
Street Apt# City State Zip

Person Responsible for Account – please check one: □ Guardian □ Father □ Mother

Emergency Contact	How did you hear about us?
_____ _____ Name Phone# _____ _____ Name Phone# I authorize Synergy to also discuss this account with the following people: _____ _____	□ Friend/Family: _____ □ Followed my therapist □ Website □ Internet Search □ Facebook □ Drive by □ Physician □ Workshop at Synergy □ Insurance company: _____

Insurance Information

Primary Insurance	Secondary Insurance
_____ (Subscriber) Last First MI _____ Birth date (mo/day/year) Relationship to Patient _____ Employer Insurance Co. & Phone # _____ _____ Subscriber # Group #	_____ (Subscriber) Last First MI _____ Birth date (mo/day/year) Relationship to Patient _____ Employer Insurance Co. & Phone # _____ _____ Subscriber # Group #

Preferred method of communication for Appointment Reminders:

☐ Email _____

☐ Text _____

Synergy HEALTHCARE FOR KIDS

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

History

Prenatal History

□Foster or adoptive parent with limited knowledge of birth history

Please indicate if any of the following occurred during the mother's pregnancy:

			Please Describe
Infections	□ Yes	□ No	_____
Illnesses	□ Yes	□ No	_____
Medications	□ Yes	□ No	_____
Drug Exposure	□ Yes	□ No	_____
Alcoholic Exposure	□ Yes	□ No	_____
Other Complications	□ Yes	□ No	_____

Birth History

Birth Order □ Single □ Twin A □ Twin B □ Multiple #____

Delivery Birth Weight Pounds _____ Ounces _____
□ Full-Term □ Premature Number of weeks_____
□ Vaginal □ Planned C-Section □ Emergency C-Section
□ Unassisted □ Assisted by Forceps □ Assisted by suction

Complications □ Breech □ Multiple Births □ Nuchal Cord
□ Premature Rupture of Membranes □ Meconium Aspiration □ Fetal Distress
□Other:_____

Hospitalization □ Regular Nursery □ Special Care Nursery □ NICU
Length of hospital stay?_____
Additional information_____

Medical History

_____Please Describe (date and frequency if applicable)

Immunization Current	□Yes	□No	_____
Hospitalizations	□Yes	□No	_____
Surgeries	□Yes	□No	_____
Seizures	□Yes	□No	_____
Heart problems	□Yes	□No	_____
Breathing difficulties	□Yes	□No	_____
Allergies	□Yes	□No	_____
Nutritional concerns	□Yes	□No	_____
Feeding Difficulties	□Yes	□No	_____
Reflux	□Yes	□No	_____
Ports, Tubes, or Shunts	□Yes	□No	_____
Casts or braces	□Yes	□No	_____
Skin breakdown	□Yes	□No	_____
Ear infections	□Yes	□No	_____
Pain issues	□Yes	□No	_____
Vision concerns	□Yes	□No	_____
Any previous infections	□Yes	□No	_____

If yes, how often, do they persist, is it sudden or gradual onset. _____

Hearing concerns □Yes □No _____

Current medications _____

Special Diets _____

Synergy HEALTHCARE FOR KIDS

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

History Continued

Does your child have a current diagnosis? □Yes □No
If yes please state_____

Who is your referring physician?
_____

Any specialists your child is currently being followed by? □Yes □No
If yes, state what for. _____

Education and Therapy History

Has your child received early intervention service or any previous therapies in the past? □Yes □No
If yes, which type and how often?
□ Physical Therapy _____ □ Occupational Therapy _____
□ Speech Therapy _____ □ Developmental Therapy _____

Is your child currently enrolled in school? □Yes □No
Name of School _____ Grade Level_____

Does your child receive therapies as part of an IEP at school? □Yes □No
If yes, which type and how often?
□ Physical Therapy □ Occupational Therapy □ Speech Therapy

Please bring a copy of your child's most recent IEP with you to your first visit.

Does your child receive behavioral therapy services? □Yes □No Name of Agency _____

Does your child currently participate in other outpatient therapies? □Yes □No If yes, which type and how often?
□ Physical Therapy _____ □ Occupation Therapy _____
□ Speech Therapy _____ □ Psychological Therapy _____

Does your child have any behavioral concerns? If yes, what methods are you currently using?
_____

_____

Developmental History

At approximately what age did your child begin to do the following without help?

Roll Over	_____	Eat Table Food	_____	Drink From Cup	_____
Sit	_____	Crawl	_____	Feed Self w/Utensils	_____
Walk	_____	Say First Word	_____	Say Sentences	_____
Run	_____	Jump	_____	Ride Bike	_____

Other concerns in this area:_____

How does your child sleep? □Good □Fair □Poor
Any concerns with sleep?_____

How does your child eat? □Good □Fair □Poor
Infant Feeding □Breast □Bottle □Baby Food □Table Food

Synergy HEALTHCARE FOR KIDS

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

History Continued

Any concerns with feeding? _____

Does your child take a multivitamin or supplements □Yes □No

Please list Vitamins/supplements:_____

Language Development

Age when child: Spoke first word_____ Combined words_____ Spoke in sentences_____

What was your child's first word(s)?_____First sentence_____

Which sounds (if any) are incorrect?_____

How many words can your child say (list if fewer than 15)?_____

_____

Does your child have difficulty with understanding you? □Yes □No

Does your child have difficulty following directions? □Yes □No

Any speech or hearing problems in the immediate or extended family (explain)?_____

_____

Social Development

Other adults living in the home:_____

Moves prior to age 10:_____

Relationship with peers:_____

Activities shared with parents and siblings:_____

How does your child handle frustration:_____

Conflict:_____ Separation:_____

Regular responsibilities:_____

Favorite: place_____ people:_____ toys:_____

Snacks:_____ activities:_____ TV:_____

What motivates your child the most?_____

_____

What are your child's strengths? _____

_____

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

History Continued

What are your child's weaknesses? _____

_____

What are your main concerns?

_____

_____

_____

_____

_____

Additional Information

Do you have religious, dietary, or cultural needs that you would like for us to be aware of? _____

_____

_____ _____

Parent/ Guardian Signature Date

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

Notice of Privacy Practices Acknowledgement:

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that Synergy Healthcare for Kids Inc. *Notice of Privacy Practices* has been made available to me, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Guardian _____ _____
Signature **Date**

Patient Agreements:

As the parent/legal guardian of _____, I authorize his/her therapy evaluation and treatment.

I understand Synergy Healthcare for Kids Inc. does their best to work within the confines of my insurance plan, however I am responsible for keeping track of the details of my specific insurance plan including: required referrals or prescriptions, insurance authorizations, benefit limits, co-pays, coinsurance and deductibles.

I authorize my/my child's insurance company to make payments directly to Synergy Healthcare for Kids Inc.

I authorize Synergy Healthcare for Kids to release all information, including my medical history and other information, required for processing health insurance claims or to assist in coordinating care.

I understand that if the insurance does not cover the billed amount, I am responsible for the unpaid balance. I understand that if I have an unpaid balance with Synergy Healthcare for Kids Inc. , a minimum monthly finance charge will be applied of $2.00 up to 1% of my end of the month balance. In case of default payment I am responsible for any legal interest, collection costs and reasonable attorney's fees. There is a $25.00 return check fee on all unpaid checks to Synergy Healthcare for Kids Inc.

The information on the patient information page and medical history is correct to the best of my knowledge.
I request and consent to receive treatment at Synergy Healthcare for Kids Inc.

I understand that my health is important and will take necessary steps to improve it under the guidance of Synergy Healthcare for Kids Inc. highly trained therapists.

Patient/Guardian _____ _____
Signature **Date**

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

Insurance Agreement:

Billing insurance is a courtesy of any healthcare practice. We expect the insurance information provided by you to be accurate. If your insurance requires authorization and the insurance provided is inaccurate, you agree to be responsible for the cost of treatment. If there is a change in your insurance coverage and you do not immediately notify us, you will be held responsible for any charges incurred.

Patient/Guardian _____ _____
Signature **Date**

ACCOUNT GUARANTOR (person(s) financially responsible for patient account)
Guarantor Full Name _____ **DOB:** _____
Social Security Number _____-_____-_____ **Primary Phone (**_____**)**_____
Street Address (no PO Box) _____ **Apt/Suite** _____
City _____ **State** _____ **Zip** _____
Employer _____ **Employer's Phone (**_____**}**_____

Appointment Policy:

Timeliness: Please arrive at least five minutes early to the scheduled appointment. If you are late to your appointments, a different time may be offered if available. Your appointment may be shortened, or you may lose out on the opportunity to partake in your therapy session that day.

Parent and Sibling: Parents are required to stay on site during therapy sessions, and are encouraged to observe and participate in their child's therapy session. Time will be allowed within the sessions for you and the therapist to discuss home program recommendations and your child's progress. Siblings are the responsibility and under the supervision of parents, however if appropriate, we try to encourage involvement in therapy sessions for the benefit of your family. Siblings must stay in the same area as parents and treated sibling. It is required they ask the therapist's permission before using any equipment, games, supplies, or activities.

Cancellation and No-Show: Synergy Healthcare for Kids Inc. requires 24 hours notice prior to canceling your appointment. If you do not comply with this policy or no-show for your appointment you are at risk of being discharged for a period of time.

When you don't show as scheduled, three people are hurt: 1) Your child, because they don't get the treatment they need as prescribed by the doctor and/or OT. 2) The therapist who now has space in their schedule because the time was reserved for you personally; and 3) Another patient who could have been scheduled for treatment if you had given proper notice.

An average of 80% attendance rate is expected for ongoing treatment. Clinic closures and Provider unavailability will not affect your attendance average. Three No Call-No Shows or three consecutive canceled sessions without approved absence reason; will result in immediate discharge from the program. Discharge due to absence will be reported to your physician. We do ask that in the event that life presents an obstacle making it difficult to regularly attend appointments to let us know so we can work together to find a solution.

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

Illness: Your therapist works in close contact with many people, including medically fragile children that become ill very easily. Please be respectful and cancel your child's appointment if your child (or anyone that will attend the appointment with him or her) is ill. You should cancel your child's appointment if he or she has any of the following: Vomiting, Fever over 100 degrees, Lice, Diarrhea, Red or runny eyes, Chickenpox, Rash, Cough or nasal drainage, Antibiotic therapy - first 24 hours, or COVID diagnosis.

Therapist Cancellations: Synergy Healthcare for Kids Inc. will notify you as soon as possible if we must cancel your appointment due to therapist illness or unsafe weather conditions for home visits.

I have read, understand, and agree to the above listed policies.

Patient/Guardian _____ _____
Signature **Date**

Behavior Policy:

At Synergy Healthcare for Kids, Inc. , the safety of our therapist and your family is our priority. We implement a firm behavioral policy for any type of verbal or physical aggression or abuse at our office, which may place our therapist, staff or other families at risk. We reserve the right to protect the safety of all clients at our office and our professionals that work at Synergy Healthcare for Kids, Inc.

If an incident of verbal or physical aggression from a client or caregiver occurs towards our staff or other families present in our office, the aggressor may be asked to leave and seek services elsewhere. If an incident occurs at the office and with the therapist's discretion you are not asked to leave, our therapists will develop a behavior plan of action with your family in lieu of how to proceed if the behavior happens again. It is up to the therapist's discretion if they feel calling 911 is needed to protect the safety of themselves, the family, or other clients in the office.

We are requiring parents and/or caregivers to be present during all therapy sessions. When a parent or caregiver is present, we can provide more information for progress toward therapy goals, teach home strategies, as well as reduce liability for any party if an incident were to happen in your absence.

Synergy Healthcare for Kids, Inc. staff will do our best to make an effort to plan with your family to assist in decreasing behaviors, however it is up to the therapist's discretion for the safety of staff and other families at our office whether or not the client/family in question will be able to continue to seek services with Synergy Healthcare for Kids.

Furthermore, if your child is not toilet trained, we ask that you remain on the premises in case that diapering is needed during the session and for the comfort of your child. Diapering is not the responsibility of the therapist working with your family unless it has been addressed as a therapy goal that the therapist has set up for your child.

I have read, understand, and agree to the above listed policies.

Patient/Guardian Signature_____ **Date** _____

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

WAIVER AND RELEASE OF LIABILITY:

In consideration of the risk of injury while participating in ***Use of Gym Equipment*** (the "Activity"), and as consideration for the right to participate in the Activity, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge Synergy Healthcare for Kids Inc. , located at 6270 N Government Way, Dalton Gardens, Idaho 83815, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL, OR THE CONDITION OF THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless Synergy Healthcare for Kids Inc. against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If Synergy Healthcare for Kids Inc. incurs any of these types of expenses, I agree to reimburse Synergy Healthcare for Kids Inc. I acknowledge that Synergy Healthcare for Kids and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Synergy Healthcare for Kids Inc.

I ACKNOWLEDGE THAT THIS ACTIVITY MAY INVOLVE A TEST OF A PERSON'S PHYSICAL AND MENTAL LIMITS AND MAY CARRY WITH IT THE POTENTIAL FOR DEATH, SERIOUS INJURY, AND PROPERTY LOSS. The risks may include, but are not limited to, those caused by terrain, facilities, temperature, weather, lack of hydration, condition of participants, equipment, vehicular traffic

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

and actions of others, including but not limited to, participants, volunteers, spectators, coaches, event officials and event monitors, and/or producers of the event.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE SYNERGY HEALTHCARE FOR KIDS INC. AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST SYNERGY HEALTHCARE FOR KIDS INC. FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Synergy Healthcare for Kids Inc. , its agents, and employees.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

This Agreement was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both the Participant, _____, and Synergy Healthcare for Kids Inc. agree that this Agreement is clear and unambiguous as to its terms, and that no other

evidence will be used or admitted to alter or explain the terms of this Agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

In the event of an emergency, please contact the following person(s) in the order presented:

Emergency Contact **Contact Relationship** **Contact Telephone**

_____

_____

_____

In the event that the participant is under the age of consent (18 years of age), then this release must be signed by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

Parent / Guardian Name: _____

Relationship to Minor: _____

Signature: _____

Date: _____

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

Release of Liability
Parent Drop Off:

Synergy Healthcare for Kids Inc. encourages parents to observe and participate in their child's therapy session. Please notify your therapist in the event you have special circumstances that will not allow you to attend a therapy session. It will be up to the discretion of the therapist to continue the session without you.

I, _____ as parent/guardian of

_____ (child) do hereby give a release of liability to

Synergy Healthcare for Kids Inc. when _____ (child) is left at the clinic without a parent/guardian in attendance.

A sign in sheet will be used at the Synergy Healthcare for Kids Inc. clinic. When the child arrives the parent must sign the child in.

Parent/Guardian Printed Name: _____

Signature of Parent/Guardian: _____ Date: _____

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

Media Permission:

Photograph Consent

I, _____ as Parent/Guardian of _____

do hereby give my permission for _____ to be photographed for the potential use on our brochure or website for Synergy Healthcare for Kids Inc.. I understand the pictures may be reviewed by other professionals for educational or learning purposes in accordance with the practice field of Occupational Therapy, Speech therapy, and Physical Therapy, and by the parents or individuals viewing our website or brochure.

_____
Print Name

_____ _____
Signature Date

This signed statement is designed to protect the clients, families and employees of Synergy Healthcare for Kids Inc.. No Information regarding vital statistics of clients will be shared with anyone other than Synergy Healthcare for Kids Inc.

Synergy HEALTHCARE FOR KIDS

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

CODE OF CONDUCT:

Here at Synergy Healthcare for Kids we care about all of our families. We want everyone to feel safe and supported. In order to promote a safe and healthy environment for staff, visitors, patients and their families we expect visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- Questions about your billing can be addressed by speaking with our front administration staff.
- If you have any questions about the care or are unhappy with the service received in our office, please contact our practice manager or therapist before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the therapist at the time of your scheduled appointment, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the therapist can give all patients the time and quality of care they deserve.
- Our practice follows a zero-tolerance policy for aggressive behaviors.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children at all times.

The following behaviors are prohibited:

- Possessing firearms or any weapon on the premises.
- Intimidating or harassing staff or other patients.
- Making threats of violence, cursing, and/or the use of abusive language through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication.
- Physically assaulting or threatening to inflict bodily harm.

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

- Damaging business equipment or property.
- Making racial or cultural slurs or other derogatory/menacing remarks and/or gestures.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member.

Violators are subject to removal from the facility and/or discharge from the practice.

Thank you for your support in promoting a safe and healthy environment for all at Synergy Healthcare for Kids, Inc.

_____ _____

Parent/Guardian Signature ***Date***

Synergy HEALTHCARE FOR KIDS

6270 N. Government Way
Dalton Gardens, ID 83815
Phone: (208) 666-0611
Fax: (208) 664-0566
www.synergyidaho.com

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEHEALTH THERAPY & CONSULTATION SESSIONS

The purpose of this form is to obtain your consent to participate in telehealth sessions with any of the following pediatric specialists: Speech & Language pathologists, Occupational Therapists, and Physical Therapists.

1) **Purpose and Benefits.** The purpose of this is to use telehealth to enable clients living in rural and/or underserved areas and/or during emergency situations to get medical care by specialists without the inconvenience, expense, or contraindication of traveling to a clinic.
2) **Nature of Telehealth Session: During the telehealth session and consultation:**
   a) Details of your child's medical history, evaluations, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
   b) Physical examination and observation of your child may take place.
   c) Nonmedical technical personnel may be present in the telehealth studio to aid in video transmission.
   d) Video, audio, and/or digital photo may be recorded during the telehealth sessions.
3) **Medical Information and Records.**
   All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth session. Additionally, dissemination of any client-identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.
4) **Confidentiality**. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth session. All existing confidentiality protections under federal and Idaho State law apply to information disclosed during this telehealth session.
5) **Risks and Consequences**. The telehealth session will be similar to a routine therapy clinic session, except interactive video technology will allow you to communicate with a therapist at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct client to therapist contact. Following the telehealth session, your therapist may recommend an in-person session to Synergy Healthcare for further evaluation and treatment.
6) Rights. You may withhold or withdraw consent to the telehealth session at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the specialist in person if you travel to their location.

I have been advised of all the potential risks, consequences and benefits of telehealth. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above. I give my consent to share my email with the telehealth platform system to schedule my appointments.

Childs Name:_____ **DOB:**_____

Signature:_____ **Date:**_____
Parent or Guardian (or authorized to give consent)

Name:_____ **Relationship to Child**_____