



568 Communipaw Ave.  
Jersey City, NJ 07304  
(T)201.309.0198  
LM4SDjc@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#: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_- \_\_\_\_\_ Secondary Contact: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_- \_\_\_\_\_  
Please Circle: (Home/Work/Cell) Please Circle: (Home/Work/Cell)  
Email: \_\_\_\_\_ 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)

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

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List current school or childcare provider:

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List previous school/daycare experiences:

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

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**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):

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What are your child's strengths?

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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?

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Describe how your child gets along with other children

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**YOUR CHILD’S LIKES/DISLIKES**

Please answer the following to the best of your knowledge:

What are some things your child dislikes?

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

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What are your child’s favorite foods?

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

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**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:

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

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

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**YOUR COMMENTS/CONCERNS**

Please answer the following to the best of your knowledge:

Please describe any mealtime routines or concerns:

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Please describe any bedtime routines or concerns:

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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:

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**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?

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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:**

**Self – Pay Fee Schedule:**

- Occupational and Speech Therapy Evaluations and Reports start at \$450.00. This includes a comprehensive evaluation of up to (4) four hours depending on the number of assessments administered, scored, interpreted, and reported. A consultation with family is scheduled and a written report will be emailed at the family’s convenience.
- Combination Occupational and Speech Therapy Evaluations and Reports are also available and start at \$750.00
- Individual treatment for Occupational Therapy and/or Speech Therapy is \$150.00. This includes a 50-minute individual treatment session, (5) five minutes allotted for a progress note and (5) five minutes allotted for a consultation with a caregiver.

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:

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(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.

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(Signature of Parent/Guardian)

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(Today’s Date)

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Print Parent/Guardian’s Full Name

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(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: \_\_\_\_\_