Foundation Music School

Music Therapy Services

Using music to address clinical, therapeutic goals for individuals and groups in the Fort Collins area

The entire staff at *Foundation Music School* would like to thank you for choosing us and welcome you to our family.

It is our goal at *Foundation Music School* to provide you with outstanding services, support, and communication regarding your family's needs. We provide an environment that is encouraging, well-informed, enjoyable, and sincere. We want you to be an integral and active participant in your child's therapy and learn how to provide an environment for your child and family that will support his/her development. We also want you to be involved in establishing goals, treatment planning, home exercises, and discharge planning. Our intention is to move towards a level of independence within everyone's abilities.

Included in our paperwork you will find:

1. family/patient information sheet
2. financial agreement/attendance policy
3. consent to treat/medical release/permission for exchange of info
4. permission to leave site
5. Audiovisual release
6. HIPAA policy

Please read all forms thoroughly so that you are informed about the agreements you are signing, and ask any questions to better help us serve you and your family.

Additionally, some other pieces of information ***may*** be requested. We will notify you if they are needed:

A. Copy of driver's license
B. Current prescription from PCP – Must state MT services 1x a week, for 12 months for specific diagnoses
C. Most recent OT/ST/PT/Psychological evaluations within the past year
D. Waiver and/or Grant information (if applicable to your child)

Please note this completed paperwork MUST be received prior to your child's initial evaluation. If they are not received prior to your first appointment, we ask that you arrive 30 minutes early in order to complete your paperwork. Upon receipt of these signed documents, *Foundation Music School* will upload the information into a secure, double-password protected document vault specific for each client. All paper copies of these documents will be shredded and disposed. Please note that should any information contained in this paperwork change, it is the responsibility of the parent/guardian to notify *Foundation Music School* as soon as possible.

We look forward to working with your family.

Thank you,

Karen Parsell, MM, MT-BC
Executive Director

Nicole Wilshusen, MM, MT-BC
Assistant Director

Foundation Music School ~ Music Therapy Services
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Client Information Form

Client's Name_____DOB:_____ M or F

Parents' Names _____

Address:_____City:_____Zip:_____

Cell Number:_____Home Number:_____

Email:_____ **Please circle preferred method of communication*

Diagnosis (if known) _____

Primary Physician:_____

Physician's Address & Phone:_____

Other doctors & therapists involved in your child's care:

Name	Specialty	Phone Number

How did you hear about Foundation Music School?_____

_____

CES/SLS/Case Worker Information:

Has your child been approved for the Colorado CES waiver or SLS? _____

Case Worker's Name: _____

Case Worker's Email and Phone Number:_____

I understand and agree to the Foundation Music School Notice of Privacy Practice.

Signature_____ **Date:** _____

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Family Background

Mother's Name:_____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Marital Status: □Married □Divorced □Separated □Widowed

Languages spoken at home: (circle primary) _____

Brother(s) and/or Sister(s) of the child:

Name	Age

What are your priorities in coming to Foundation Music School?

_____

_____

_____

Does your child currently receive other therapy services? □Yes □No

If Yes, where and when? _____

_____

_____

Medical History

At how many weeks was your child born? _____ Birth weight? _____

Were there any complications during the pregnancy or delivery? □Yes □No Please describe: _____

_____

Was your child hospitalized after birth?_____

_____

Does your child have any other medical issues? _____

_____

Please list any hospitalizations and/or medical procedures your child has received: _____

_____

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Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies? □Yes □No **If yes, please describe:** _____

_____

Any diet restrictions? □Yes □No **If yes, please describe:**_____

_____

Education Information

Is your child currently enrolled in school? □Yes □No

If Yes, where and days attended: _____

Does your child receive any services through the school? □Yes □ No

If Yes, what services? _____

Does your child have a current Individualized Education Plan (IEP)? □ Yes □ No

Social/Emotional History

What are your child's favorite activities? _____

What are your child's favorite songs? _____

What typically calms/soothes your child? _____

Is your child currently enrolled in any community activities (music classes, play groups, swim lessons, sports) _____

_____

Anything else you would like to tell us about your family? _____

_____

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PRINTED NAME **RELATIONSHIP TO CHILD**

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PERMISSION FOR EXCHANGE OF INFORMATION

I authorize *Foundation Music School* to release necessary and pertinent medical information to physicians, case managers, and insurance companies as needed for my child.

Approved information may be exchanged with the following people directly related to my child's care:

□ Other therapists_____

□ School name: _____

□ Please list any others: _____

_____

Approved information includes **written documents** and/or **verbal discussion**.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

PERMISSION FOR PARENT TO LEAVE SITE DURING TREATMENT

I _____ (Parent or Legal Guardian) acknowledge that I am the parent of

_____ . I understand that while my child is receiving therapy I may leave the premises. However, I will give *Foundation Music School* a working cell phone number where I can be reached during my absence. In addition, I agree that I will return prior to the end of the session. I give consent and permission to *Foundation Music School* for any additional treatment or transportation that may be needed in the event that my child is injured or needs medical attention. Also, I understand that the ability to continue to leave the premises while my child is at therapy is at the discretion of *Foundation Music School* and/or my child's therapist.

EMERGENCY CONTACTS:

Other than you, who is authorized to pick up your child from their session? Please include additional parents/family members other than yourself:

Name	Number	Relationship

Who is **NOT AUTHORIZED** to pick up your child?

Name	Relationship

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I hereby release *Foundation Music School*, and any agents or assignees, from any and all claims for damages related to my leaving the premises during my child's therapy.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PRINTED NAME **CELL PHONE**

CONSENT FOR AUDIO/VISUAL RELEASE:

I, _____*(Parent/Legal Guardian)* give permission for _____ *(Child)* to be audio or video taped by the teachers at *Foundation Music School*. These audio or video taped sessions will be used for education and training purposes only (i.e. teacher trainings & continuing education, conference presentations) At no time will the student's full name be spoken on the tapes and the student's full identity will remain confidential. These tapes may be maintained in a locked facility.

_____ ---

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

CONSENT FOR PHOTOGRAPH RELEASE:

I _____*(Parent/Legal Guardian)* give permission for _____ *(Child)* to be photographed by the teachers at *Foundation Music School.* These photographs will be used for education and training purposes (i.e. teacher trainings & continuing education, conference presentations) , and may be used by Foundation Music School for advertisement purposes (i.e. brochures, newspapers).

_____ ---

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

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PERMISSION FOR MEDICAL TREATMENT / EXCHANGE OF INFORMATION

I do hereby state that I have legal custody and grant my authorization and consent for *Foundation Music Schoo*l to administer general first aid treatment for any minor injuries or illnesses experienced by my child:

CHILD'S NAME:_____.

If the injury or illness is life threatening or in need of emergency treatment, I authorize *Foundation Music Schoo*l to summon any and all professional emergency personnel to attend, transport, and treat my child and to issue consent for any hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of *Foundation Music School* in the exercise of their best judgment upon the advice of any such medical or emergency personnel. I authorize *Foundation Music School* to release necessary and pertinent medical information to physicians or first responders as needed for my child.

Approved information includes **written documents** and/or **verbal discussion**.

Information for Medical Treatment

Physician's Name and Location of Practice: _____

_____

Physician's Phone: (_____)_____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

Please note all conditions for which the child is currently receiving treatment:

_____

_____

Note any other significant medical information:

_____

_____

Authorization/Liability Waivers

I certify that my child is enrolled in a regular medical program and has been examined by a doctor within the last 12 months. parent initials_____

In case of emergency, I give my consent to Foundation Music School to seek medical care for my child should it become reasonably necessary in the course of such activities. parent initials_____

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Permission to Treat

I hereby give my permission to trained medical professionals to administer emergency medical treatment to my child should sickness or accident occur in my absence. If hospitalization is required, the aforementioned child will be sent to the nearest hospital unless otherwise specified here:_____

parent initials_____

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

FINANCIAL POLICY

Medicaid is not accepted except through a third party provider (ie Foothills Gateway). If authorization is required, therapists will submit based on need. Services will be administered after approval has been obtained. *Foundation Music School* accepts the Colorado CES & SLS waivers; however, pre-authorization must be approved.

_____ parent initials

An initial evaluation for music therapy services is $90/hour. Evaluations are an out-of-pocket expense expected at the time of service. An initial evaluation will be needed for all children starting therapy with our facility. Most evaluations will last 30 minutes to 1 hour, including parent consult. If a family needs a re-evaluation for any reason, the rate will be $90/hr. Financial arrangements will be made prior to the time of evaluation.

_____ parent initials

CONSENT TO TREAT

I, _____ consent for *Foundation Music School* to provide my child,

_____ with Music Therapy services. I consent to care and treatment falling under the practice guideline of the American Music Therapy Association (AMTA), and the State of Colorado. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

_____ ----------

PARENT/GUARDIAN SIGNATURE **DATE**

PRINTED NAME_____

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ATTENDANCE POLICY:

Regular attendance at sessions and parental support are the essential elements necessary for consistent progress toward goals and objectives. Therefore, students are expected to attend all sessions as scheduled. It is the student's and/or parent/guardian's responsibility to contact the therapist if a session will be missed. Sessions must be cancelled with 24-hour notice in order for rescheduling.

If a session is not cancelled with 24-hour notice and the session is missed or if the student is more than 10 minutes late, it is up to the discretion of the therapist whether the session should be rescheduled/forfeited or charged as a no call/last minute cancellation. After a one-time no call/last minute cancellation occurrence, sessions will be charged to or deducted from your account for EACH missed session.

To that end, we require a current credit card be placed on file at all times. We will run the no call/last minute cancellation fee on the date of the expected service if there is no money currently on account to deduct the missed session from. This insures that our therapists will still receive payment in full for their time and service in preparation for the missed session.

The Board of Health considers the following signs to indicate communicable disease/illness: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, or running nose. Please be sure you are symptom free for 24-hours before resuming lessons. Please note that if you arrive at your lesson exhibiting any of the above symptoms, it is at the teacher's discretion to send you home in order to protect themselves and our other students from infectious illness.

_____ ----------

PARENT/GUARDIAN SIGNATURE **DATE**

_____

PRINTED NAME

CREDIT CARD AUTHORIZATION:

I authorize *Foundation Music School* to maintain my credit/debit card on file. I understand that my card will only be used if: (a) My account has been **delinquent for more than 90 days** and I have not made any effort to make payment arrangements and/or (b) My appointment is **cancelled with less than 24 hours notice** or a **"no show"** occurs for a scheduled appointment. The fee for a late cancellation and/or no show is $50 for each missed 30-minute appointment.

Credit Card Number: _____Expiration Date:_____3-digit Code: _____

Name on card: _____Phone:_____

Cardholder's address:_____

_____ _____

Cardholder Signature **Date**