Foundation Music School

Music Therapy Services

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

Client's Name_____DOB:_____ M or F

Parents' Names _____

Address:_____City:_____Zip:_____

Cell Number:_____Home Number:_____

Email:_____

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:_____

Family Background

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

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

Marital Status: □Married □Divorced □Separated □Widowed

Languages spoken at home: (circle primary) _____

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

If Yes, where and when? _____

_____

What are your priorities in coming to Foundation Music School?

_____

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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: _____

_____

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? _____

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What typically calms/soothes your child? _____

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

_____

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**

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**

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**

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**

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**.

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Information for Medical Treatment

Physician's Name and Location of Practice: _____

_____

Physician's Phone: (_____)_____

Allergies to Medications: _____

Allergies (Other): _____

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

_____

_____

Note any other significant medical information:

_____

_____

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**

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**

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ATTENDANCE POLICY:

Regular attendance in sessions and parental support are the essential elements necessary for therapeutic progress and development. Therefore, clients are expected to attend all sessions as scheduled. It is the parent/guardian's responsibility to contact the therapist if a session will be missed. Sessions must be cancelled with 24-hour notice in order to be considered an Early Cancel, and eligible for rescheduling. It is the policy of FMS for only 2 make-up sessions to be allowed per semester.

If a session is not Early Cancelled (24-hour notice) it will be considered a Late Cancel. When a Late Cancellation occurs, the family is responsible for payment for the session. Special note to families on waivers: A Late Cancellation isn't eligible for Medicaid billing and therefore will need to paid for by the family. Please inquire for the out-of-pocket session fees.

To that end, we require a current credit card be placed on file. Each Late Cancellation that occurs will be charged to your credit card. This insures that our Music Therapists will still receive payment in full for their time and service in preparation for the Late Cancellation.

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**

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 30 days** and I have not made any effort to make payment arrangements and/or (b) My appointment is **Late Cancelled with less than 24 hours notice**.

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

Name on card: _____Phone:_____

Cardholder's address:_____

_____ _____

Cardholder Signature **Date**

Foundation Music School ~ Music Therapy Services
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