Welcome to Jumping Jax!

We are happy you have chosen Jumping Jax, and we aim to make this experience as easy and fun as possible for both you and your child. Our goal is to walk you through each step of your child's therapy and to provide you with all the tools necessary to help him or her at home and at school. We are here to support you, so please feel free to ask us any questions you may have. We are reachable by phone at (212)877-0667, and by email at info@jumpingjaxnyc.com. We look forward to working with you!

Payment Policies

- Private-paying clients are responsible for payment of services rendered.
- Billing invoices will be created on the last day of each month. Payment for services rendered is due no later than 15 days after the invoice date. Jumping Jax reserves the right to suspend services for outstanding invoices more than 30 days overdue. Services will not be suspended without our contacting you first.
- Jumping Jax accepts personal checks, credit cards (with an additional processing fee) and cash as forms of payment.
- Jumping Jax does not accept payment from private insurance. We do, however, provide you with an invoice containing the necessary diagnostic and procedural codes to be submitted to your insurance company for possible reimbursement.

General Policies

- Jumping Jax runs on a two-semester year: September through June, and July through August. Your child will be assigned an agreed-upon therapy slot for a semester.
- Jumping Jax requires at least 24 hours notice for cancellations. Otherwise, you will be charged the full fee of the session. Additionally, you will be charged the full fee if you do not show for a session without prior notice.
- You are permitted 2 cancellations a month. Should you cancel more than 2 sessions in a month, you will be billed for any subsequent cancelled or missed sessions. Additionally, you will be at risk of losing your therapy slot.
- Please cancel if your child did not attend school due to illness, or if he/she is running a fever, has gastrointestinal problems, or has a runny nose and/or cough. A makeup session may be provided at a later date if possible.
- Only children accompanied by their treating therapist shall enter the main therapy area.
- Please inform us if someone other than the individuals designated on the intake form will be picking up your child on a given day.
- In the case of inclement weather, please call the office to find out about closure or cancellations.
- There is no eating or drinking allowed in the waiting room area.
- Jumping Jax reserves the right to terminate services if the above policies are not followed.

Parent/Guardian Agreement

Please sign and return before or at the time of your child's first treatment session.

I, _____, parent/guardian of _____, have read and understood the above policies and agree to adhere to them. I understand that Jumping Jax reserves the right to terminate services if the payment policies and/or general policies are not followed. Jumping Jax will never terminate services without prior notice.

Signature: _____

Date: _____

Jumping Jax Intake Form

Please complete the following information to the best of your ability.

Contact Information:

Child's Name: _____ Date of Birth: _____

Parent -1 Name: _____ Parent -2 Name: _____

Home Phone#: _____ Preferred Phone: □ Home □ Cell □ Work

Home Address: _____

Alternate Address: _____

Parent -1 Cell: _____ Parent 2 Cell: _____

Parent -1 Work #: _____ Parent -2 Work #: _____

Parent -1 Email: _____ Parent -2 Email: _____

Caregiver's Name: _____ Caregiver's Phone: _____

Pediatrician's Name:_____ Pediatrician's Phone:_____

Name(s) of adult(s) permitted to pick up your child: Relationship to child:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Emergency Contacts:	Phone Number:	Relationship to child:
1. _____	_____	_____
2. _____	_____	_____

Developmental History:

Labor and Delivery

At what gestational week was your child born? _____

Vaginal or c-section: _____

Birth Weight: _____

Any complications during pregnancy or during delivery: _____

Did your child spend any time in the NICU? _____

At what age did your child…

Roll over: _____ Sit up: _____

Crawl: _____ Pull to stand: _____

Walk: _____ Say first words: _____

Does your child have any difficulty with sleeping? _____

Does your child have any difficulty with eating? _____

Languages other than English spoken at home: _____

Medical History:

Has your child had tubes placed in the ears? _____

Has your child had adenoids or tonsils removed? _____

Does your child have asthma? _____

Does your child have frequent ear infections? _____

Current medications: _____

Is your child being followed by any medical specialist?_____

Has your child received previous therapy? _____

Any accidents, illnesses, surgical interventions, or hospital stays: _____

_____

_____

Vision Problems: _____ Hearing Problems: _____

Is your child potty trained? _____ If yes, at what age: _____

Food, Medicine, and/or Environmental Allergies:

_____

_____

What concerns do you have regarding your child's development or present level of functioning?

_____

_____

_____

_____

School Information:

What school does your child attend? _____

What grade is your child in? _____

What is your child's school schedule (days/times) _____

What is the name of your child's teacher? _____

May we contact the teacher with regard to your child? _____

Notice of Client Information Practices

This notice describes how medical information about you may be used or disclosed by Jumping Jax and how you can get access to information. Please review it carefully.

Legal Duty: Jumping Jax is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described here.

Uses and Disclosures of Health Information: Jumping Jax uses your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. We may also use or disclose your personal health information for public health purposes, audits, emergencies, and when required by law.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

We may change our policy at any time. When changes are made, a new Notice of Client Information Practices will be posted in our office and you will receive a new written notice as well.

Client's Individual Rights: You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Jumping Jax will consider all such requests on a case by case basis, but we are not legally required to accept them.

Concerns and Complaints: If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the US Department of Health and Human Services.

Parent/Guardian Consent to the Notice of Client Information Practices

I have read and understand the attached Notice of Client Information Practices. I understand that Jumping Jax may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify Jumping Jax. I also understand that Jumping Jax will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as outlined in the Notice of Client Information Practices. In doing so, I hereby release Jumping Jax from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying Jumping Jax in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

Parent/Guardian's Printed Name: _____

Name of Client: _____

Parent/Guardian's Signature: _____

Date: _____