# Seaside Therapy, Inc.

**4253 Transport Street, Unit 1**
**Ventura, CA 93003**
**Phone (805) 644-8255**
**Fax (805) 644-8256**

## Client Information Sheet

**Date:**_______________

**Child's Name:**_______________________ **Gender:**______ **Date of Birth:**_________

**Parent/Caregiver Name:**_______________________________________

**Parent Email Address:**________________________________________

**Address:**_____________________________________ **Apt #**__________

**City:**____________________ **State:**_______ **Zip:**____________

**Mom's #:**_______________ **Dad's #:**_____________ **Other** (specify):______________

**Primary Doctor:**_____________________________

**Group:** ______________________________

**Address:** _____________________________

**Phone:** _______________________________

**Other Specialists Involved in Care:** _____________________________________

**Primary Language Spoken in the Home:** __________________________

**Insurance Carrier:** ________________________

**Subscriber or Policy Number:** _________________________

**Insured's Name:** ________________________________**SS#:**_________________

**Insured's Date of Birth:** ___________**Insured's Employer:**_________________

**Secondary Insurance (If any)**

**Insurance Carrier:** ________________________

**Subscriber or Policy Number:** _________________________

**Insured's Name:** __________________________________

**Insured's Date of Birth:** ___________**Insured's Employer:**_________________

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# Consent to Treatment

Name of Client: ____________________________ Date of Birth: ______________

I, the undersigned, hereby consent to and authorize Seaside Therapy to administer and provide medically necessary treatment as prescribed by a physician or in the service plan to and for the above named person. I understand that such treatment is performed in accordance with the individual's licenses and certifications.

I understand that services may include therapy evaluations, treatment, verbal and written instructions, consultation, monitoring and periodic review by professionals of Seaside Therapy.

Parent/Guardian Signature: _________________________________________

Date: ____________________ Relationship: __________________________

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# Consent to Administer First Aid and Emergency Care

I consent to and authorize professionals of Seaside Therapy to administer first aid, CPR and/or emergency care in accordance with the individuals' and/or agencies' licenses, certifications, and/or training.

Parent/Guardian Signature: _________________________________________

Date: ____________________ Relationship: __________________________

**Emergency Information**

Contact Person: ________________________ Phone: ________________

Doctor: _______________________________ Phone: ________________

Insurance Name: ____________________________ Policy # _____________

Allergies: _______________________________________________________

Medication: ______________________________________________________

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Name of Client: ______________________________

## CONSENT TO OBTAIN/RELEASE MEDICAL INFORMATION

I, the undersigned, hereby consent to and authorize any and all persons and agencies to release all medical, social, psychological, or educational information regarding the above named person to Seaside Therapy, Inc and its employees. I understand that such information becomes part of Seaside Therapy, Inc,'s records and will be utilized for better understanding and future care of the above named persons.

I consent to and authorize Seaside Therapy, Inc. to release any medical and educational records to the following individuals listed below who have provided or are providing medical or educational services to the above named client.

## HIPAA

I understand that these records will be used only to coordinate medical and educational services to the above named client and that Seaside Therapy, Inc. protects the confidentiality of client information and releases information only according to the policies based on federal and state law and HIPAA standards. Only persons responsible to the direct care of the above named person are privy to information regarding the above named person.

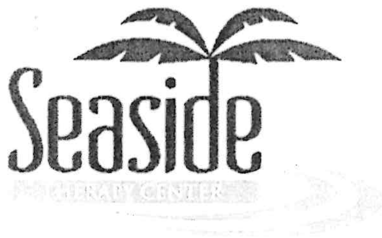
This is voluntary for you to fill out. If there are any specialists, teachers, agencies, or other professionals that you would like us to be able to exchange information, please list them below.

| Name | Address/City/Zip | Phone number |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |

I understand that Consent to Release Information is valid until the above named client turns 21 years of age. All or part of the consent to release information can be canceled or changed upon receipt of written notification from the undersigned.

Parent/Guardian Signature: ______________________________

Date: ____________________ Relationship: ____________________




**SEASIDE THERAPY CENTER**
4562 Westinghouse St., Ste. A
Ventura, CA 93003
T: (805) 644-8255
F: (805) 644-8256

# Photography Release Consent Form

Seaside Therapy would like to ask for your consent to take photographs/videos of your child. We want to ensure the safety and privacy of all individuals partaking in therapy and will not post photos without consent of parents or guardians.

These images may be used in materials including:

- Company website
- Company Social Media (Facebook, Instagram)
- Marketing and hand outs (brochures, instructional hand outs)

Seaside Therapy wants to ensure these photographs/videos are being used for the purposes above. If you become aware that these images are being used inappropriately, please inform the staff immediately.

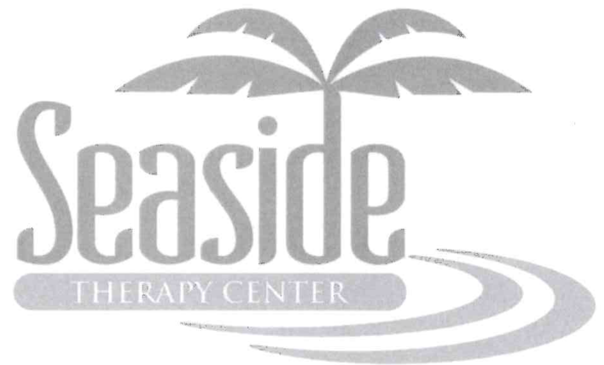
I, ________________________________, ☐ **Consent to** *OR* ☐ **Do not consent** to Seaside
*name of parent/guardian*

Therapy using photographs or videos of my child, ______________________, for purposes
*name of child*

including printed/online marketing. I wave the right to any compensation arising or related to the use of the images.

______________________________ ______________
Parent/Guardian Signature Date

# Message to Our Patients




## Appointment Cancellations:

Please give us **at least a 24 hour notice** if you need to cancel your appointment.

## Failure to Keep Appointments Without 24-Hour Notice:

While we don't charge for missed appointments, if you miss **three appointments without providing notice to our office and/or your provider**, you may be discharged from the practice.

We do understand illness and unexpected events happen but please be sure to notify us as early as possible so that we don't mark the session as a "no show".

## Late Arrivals:

Although being late is sometimes unavoidable, please be aware that the session will end at the regularly scheduled time due to subsequent appointments.

If you know you are going to be **more than 15 minutes late**, please notify our office and/or your provider immediately so we can discuss possible rescheduling. Make-up sessions and cancellations cannot be guaranteed due to provider availability. If you arrive 15+ minutes past your appointment time repeatedly, you may be asked to permanently move to another day/time which may result in a provider change (based on current appointment openings).

**Tip:** Plan to arrive 5-10 minutes early to your appointment to take care of co-payments.
**Virtual Session**: Make sure you and/or your child is logged on and ready for their session 5-10 minutes prior to appointment time.

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*I ____________________ (date signed: __________________) agree to Seaside's attendance policy for the client __________________).*

Updated April 2024