PRINT

6140 Woodside Executive Ct.
Aiken, SC 29803

(P) 803-642-0700
(F) 803-642-0588

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

SSN: _____ Sex: ☐ Male ☐ Female

Address _____
City State Zip Code

Mother's Name: _____ Age: _____ Marital Status: _____

Address _____
City State Zip Code

Phone#: _____ Cell #: _____ Work #: _____

Occupation: _____ Employer: _____

Father's Name:_____ Age: _____ Marital Status: _____

Phone # (if different): _____ Cell #: _____ Work #: _____

Address _____
City State Zip Code

Occupation: _____ Employer: _____

PRIMARY INSURANCE

Policy Holder _____ Relationship to Patient _____
Last Name First Name

Birthdate _____ SSN # _____

Address _____
(if different from Patient's) City State Zip Code

Employed By _____ Occupation _____ Bus. Phone _____

Insurance Company _____

Policy # _____ Group # _____

Additional Insurance/coverage _____

Policy # _____ Group # _____

I certify that I, and/or my dependent(s) have insurance coverage with _____ and authorize payment directly to Pediatric Therapy of Aiken or all insurance benefits, if any, otherwise payable to me for services rendered on my behalf or my dependents. The above-name may use my health care information and may disclose such information to the above-named Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian or Person Responsible Date

Please print name of Patient, Parent, Guardian or Person Responsible Relationship to Patient

Does your child attend daycare/school? Yes or No, If yes what is the name and location?

_____

REFERRAL SOURCES

Pediatrician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Other(s): _____

Please list prior therapy or evaluation(s) your child has received (Psychological, Applied Behavioral Therapy, Neurological, Physical Therapy, etc.) Please list agency, or individual provider, type of therapy, frequency and duration. _____

_____

PREGNANCY

Full-Term Yes ☐ No ☐ Premature (number of weeks at birth): _____

Vaginal Delivery: Yes ☐ No ☐ Weight:_____ Days hospitalized after birth_____

Did your infant have any complications during or following birth? Yes ☐ No ☐ If yes, please Explain: _____

_____

_____

List any prescription, non-prescription drugs (including cigarettes or alcohol) taken during pregnancy.

_____

_____

Siblings (and/or others living in the home):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

PATIENT'S MEDICAL HISTORY

Parent's description of problem(s):

_____

_____

_____

Parent's opinion of what caused the problem(s):

_____

_____

Child's age when you became concerned of possible problem(s): _____

Feeding and /or swallowing difficulties please check all that apply.

☐ sucks fingers or thumb	☐ drooling	☐ suckling
☐ chewing	☐ coughing	☐ strangling
☐ choking	☐ sensitivity to textures	☐ picky eater
☐ vomiting after or during meals	☐ Reflux	other:_____

Please list any medications your child is currently taking and the reason.

_____

_____

Are the child's immunizations up to date? Yes or No. If no please explain.

_____

Please check all conditions that your child presently has:

☐ Meningitis	☐ Cerebral Palsy	☐ Asthma
☐ CMV	☐ Epilepsy/Seizures	☐ Autism, PDD or Asperger's
☐ Hearing Impairment	☐ Vision Impairment	☐ High Fevers
☐ Acid Reflux	☐ Apraxia	☐ Neurological Disorder
☐ HIV	☐ Fragile X	☐ Stroke
☐ Traumatic Brain Injury	☐ Cleft Palate/Lip	☐ Jaw/Tongue deformity
☐ ADD or ADHD	☐ Mental Retardation	☐ Down Syndrome

Other: _____

Has your child had chronic ear infections (3 or more in a 6 month period or 4 in a year)? Yes ☐ No ☐

If yes, were tubes inserted? If so by whom and when? Are the tubes still in place?

_____

Does your child have any Medications, Food or Seasonal Allergies?

_____

Please list the date(s) of any accidents and/or injuries your child has incurred. Was hospitalization required, if so how long? _____

Has your child had any surgeries performed? If so, when and why?

_____

_____

Is there a family history of speech, language or hearing problems? If so please explain.

_____

_____

Percentage of time that your child is understood by:

_____Parents _____Siblings _____Friends _____Unfamiliar listeners

LANGUAGE DEVELOPMENT

If yes, provide the approximate age when the child began to do the following:

YES	NO		Age
☐	☐	Cooing? (ex: vowel sounds only)	____
☐	☐	Babbles? (ex: vowels & consonant)	____
☐	☐	Imitates sounds or words?	____
☐	☐	Recognizes his/her name?	____
☐	☐	Points to object or picture	____
☐	☐	Follows simple directions	____
☐	☐	Understands "No, stop or wait"	____
☐	☐	Understands "Hello or Bye-bye"	____
☐	☐	Produced first word	____
☐	☐	Vocabulary of 5-10 words	____
☐	☐	Vocabulary of 18-25 words	____
☐	☐	Vocabulary of 50 words	____
☐	☐	Combines 2 words (e.g., want cookie etc.)	____
☐	☐	Combines 3 words (e.g., I want cookie, etc.)	____
☐	☐	Form sentences with 4 or more words	____
☐	☐	Engages in conversation	____

Please list examples of words and/or phrases your child typical uses.

_____

_____

_____

_____

List things your child enjoys to be used as reinforcement for participation (e.g. foods, singing, games, cartoons, stickers, etc.)_____

_____

MOTOR DEVELOPMENT

Please provide the approximate age when your child began to do the following:

_____Raised head	_____Rolled over	_____Sat alone
_____Crawled	_____Standing	_____Walking
_____Running	_____Jumping	_____Climbing Stairs
_____Zipping	_____Buttoning	_____Dressing
_____Undressing	_____Copying	_____Cutting
_____Coloring/Scribbling	_____Throwing ball	_____Riding tricycle
_____Toileting	_____Tying Shoe	_____Drinking from cup
_____Feeding self finger foods	_____Feeding self with utensils	

SOCIAL, EMOTIONAL AND BEHAVIORAL DEVELOPMENT

Please check all behaviors that your child currently exhibits:

☐ Depression	☐ Anxiety	☐ Distractible
☐ Hyperactive	☐ Short Attention span	☐ Nervous
☐ Temper Tantrums	☐ Shy	☐ Destructive
☐ Slow Learner	☐ Unusual fears	☐ Cries easily
☐ Rocks	☐ Bangs head	☐ Stares off
☐ Flaps hands	☐ Prefers to play alone	☐ Problems tolerating sounds
☐ Demands excessive attention	☐ Picks, pulls, scratches, and/or bites him/herself	
☐ Difficulty interacting with peers, animals or adults		

Does your child exhibit any additional behaviors that concern you?

_____

_____

Please provide any additional information that might be helpful in evaluating or addressing your child's communication and/or developmental deficits.

_____

_____

_____

EMERGENCY CONTACT(S)

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

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CONSENT TO TREAT & HIPAA AUTHORIZATION

Patient's Name _____ **Date of Birth** _____
(Please Print)

I hereby authorize use or disclosure of protected health information about my child as described below.

1. **Pediatric Therapy of Aiken, LLC and its employees/contractors are authorized to use or disclose health information that is pertinent or required for therapy purposes.**
2. **Pediatric Therapy of Aiken, LLC may disclose health information considered pertinent to therapy to a patient's insurance company, physician, psychiatrist, teacher, or social worker.**
3. **I understand that Pediatric Therapy of Aiken, LLC will be disclosing protected health information to a patient's insurance company, physician, psychiatrist, teacher, social worker and/or Law Enforcement Agencies (if necessary). I also understand that the information used or disclosed may be subject to multiply disclosures by the individual or facility receiving the information.**
4. **I may revoke this authorization by notifying Pediatric Therapy of Aiken, LLC in writing of my desire to revoke permission. However, I understand that any action taken previous to reliance on this authorization cannot be reversed, and my revocation will not affect those actions.**
5. **The authorization expires when a patient is discharged by Pediatric Therapy of Aiken, LLC or receives a written notice to revoke authorization.**
6. **I do here by give my consent for Speech, Occupational and Physical Therapy according to the guidelines established by the referring physician and the therapist.**
7. **Prior notification will be made to the parent and or guardian before any information is released.**

_____ _____
Signature of Parent or Guardian **Date of Signature**

Relationship to Patient_____

_____ _____
Signature of Therapist **Date of Signature**

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ATTENDANCE POLICY

1. Regular attendance is required of all clients scheduled. Patient's will not benefit from sporadic intervention
2. Client's that cancel frequently or fail to attend scheduled appointments will be discharged.
3. When clients are consistently tardy the therapist has the discretion to cancel further sessions.
4. If a client is unable to keep an appointment for a therapy session, the clinic should be notified 24 hours in advance (when possible). The voicemail is available 24 hours a day. Please state the reason for cancellation.
5. For clients receiving therapy in the home it is essential that you are at the home when the therapist arrives.
6. For patients receiving therapy in the clinic, parents/guardians can observe sessions as desired. Parents are not required to do so unless requested by the therapist for therapeutic educational purposes.
7. Please feel free to contact management if special consideration is needed, or if you have questions regarding this policy.

_____ _____

Parent or Guardian's Signature: Date

THERAPIST RESPONSIBILITY TO PATIENT:

1. You will be contacted immediately if the therapist is unable to keep a scheduled appointment.
2. Appointments will be rescheduled whenever possible.
3. If there is a schedule conflict the therapist will work with you to determine a more appropriate day and time for therapy.
4. Provide written and or verbal family education to assist with the carry-over of therapeutic activities in the home.

_____ _____

Therapist's Signature Date

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PAYMENT/INSURANCE POLICY

Medicaid Patients: I _____ understand that I am financially responsible for all charges incurred if my child's Medicaid is terminated for any reason. It is also my responsibility to be aware of and inform Pediatric Therapy of Aiken, LLC of any and all changes in coverage.

Babynet (as primary coverage) Patients: I _____understand that Babynet will be billed for my child's therapy services until he/she turns three years of age. After my child turns three years of age, if I choose to continue services with Pediatric Therapy of Aiken, LLC, I will be financially responsible for any and all charges.

Medicaid or Babynet (as secondary coverage): I _____understand that my child's private insurance company will initially be billed for services rendered from Pediatric Therapy of Aiken, LLC. If my child's private insurance provider denies coverage, Medicaid or Babynet will be charged on my child's behalf.

Uninsured Patients: Pediatric Therapy of Aiken, LLC is dedicated to providing quality affordable healthcare to all patients. Please inform management immediately if your child does not have insurance or if insurance is terminated. We will discuss available payment policies.

Private Health Insurance Patients:

Pediatric Therapy of Aiken, LLC will file all charges incurred with your insurance company. **Please be aware that many private insurance companies only pay for medical diagnoses that are congenital (present at birth) or related to an accident or injury.** Knowing your insurance benefits is your responsibility. You are strongly encouraged to contact your insurance company with any questions regarding your policy. Please inform us immediately of any changes in insurance coverage or providers.

I, _____ understand that I am responsible for all charges incurred and will be held liable for payments in full if my child's private insurance provider denies coverage.

All co-payments are due when services are rendered.

Patient's Name (Please Print) _____

_____ _____
Signature of Parent or Guardian Date

_____ _____
Therapist's Signature Date