Patient Information

Patient's Name: Date of Birth: mm/dd/yyyy

SSN: Sex: ☐ Male ☐ Female

Address:
Street City State Zip Code

Mother's Name: Age: Marital Status:

Address:
Street City State Zip Code

Phone#: Cell #: Work #:

Occupation: Employer:

Father's Name: Age: Marital Status:

Address (if different):
Street City State Zip Code

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

Occupation: Employer:

Insurance Information

Policy Holder: Relationship to Patient:
First Last

Birthdate: SSN: Employer:

Address:
Street City State Zip Code

Insurance Company: Policy #: Group#:

Additional Insurance: 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 Date

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Referral Sources

Pediatrician: Phone:

Referring Physician (if Different): Phone:

Prior Therapy (if any) (List all types, dates, providers, frequency, and duration):

Medical History

What is the current reason for coming to therapy?:

Current Review of Systems		
Symptom (please check any and all that currently apply)	**Yes**	**No**
Unintentional weight change		
Chronic pain		
Difficulty seeing/hearing/double vision		
Chest pain/palpitations/fainting/sweating		
Nausea/vomiting/reflux		
Dizziness		
Weakness/numbness/tingling		
Depressed mood/sleep problems/anxiety/agitation/mood swings		
Pain/spasticity/dystonia/abnormal gait (walking)/joint swelling		
Scoliosis/kyphoscoliosis		
Rash/sores/eczema/itching/ecchymosis/non-healing wounds		
Sickle cell/anemia/bleeding disorder		
Diabetes		
Thyroid disease/lupus/excessive fatigue		
Any other signs/symptoms to report		
Please explain any boxes checked "Yes." Be specific:		

Are all immunizations up-to-date?: ☐ Yes ☐ No If no, please explain:

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Past Medical/Surgical History								
Check all that apply	**Yes**	**No**	**Check all that apply**	**Yes**	**No**	**Check all that apply**	**Yes**	**No**
Developmental delay			Seizure disorder			Head injury		
Hydrocephalus			Torticollis			Glasses/contacts		
Autism			ADD/ADHD			Learning disabilities		
Problems with speech			Hearing aides			Ear tubes		
Frequent ear infections			Nose bleeds			Sinus infections		
Frequent strep throat			Bleeding gums			Tracheostomy		
Tonsillectomy			Appendectomy			Dental surgeries		
Aspiration pneumonia			Acute/chronic lung disease			Frequent suctioning		
Viral/bacterial pneumonia			Asthma			Heart murmur		
Patent ductus arteriosus			Cardiac surgery			Congenital heart defect		
Gastroesphageal reflux			G-tube placement			J-tube placement		
Chicken pox			Nissen fundoplication			Liver disease		
Urinary tract infections			Kidney disease			Trauma		
Contractures			Hip subluxation/dislocation			Spinal fusion		
Soft tissue surgery			Rhizotomy			Other conditions		
Please explain any boxes checked "Yes." Be specific:								

Has the patient had any x-rays?: ☐ Yes ☐ No If yes, what was the date: _____ mm/dd/yyyy

Has the patient had an MRI?: ☐ Yes ☐ No If yes, what was the date: _____ mm/dd/yyyy

Date of last swallow study?: _____ mm/dd/yyyy Most recent blood work date: _____ mm/dd/yyyy

Medications/Allergies

Medications		
Drug	**Dose**	**Frequency**

Does the patient have any allergies?: ☐ Yes ☐ No

What kind?: ☐ Drug Allergy ☐ Food Allergy ☐ Latex Allergy ☐ Other Allergies

Allergens: _____

Reactions: _____ Medications for Allergens: _____

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Patient Health Questionnaire

Describe your symptoms:

When did your symptoms begin?:

How did your symptoms begin?:

How often do you experience these symptoms?:

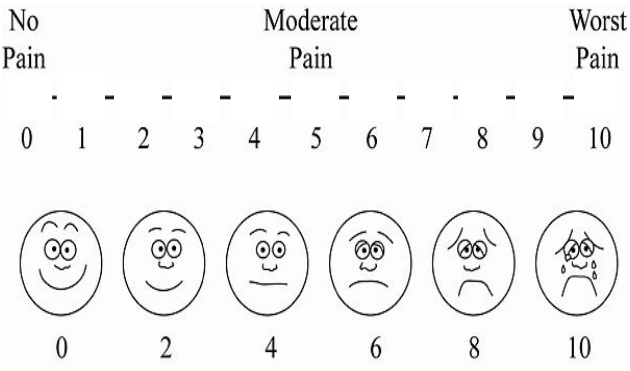
Have you ever had a problem like this before?:

Have you ever had physical, occupational, or speech therapy before?:

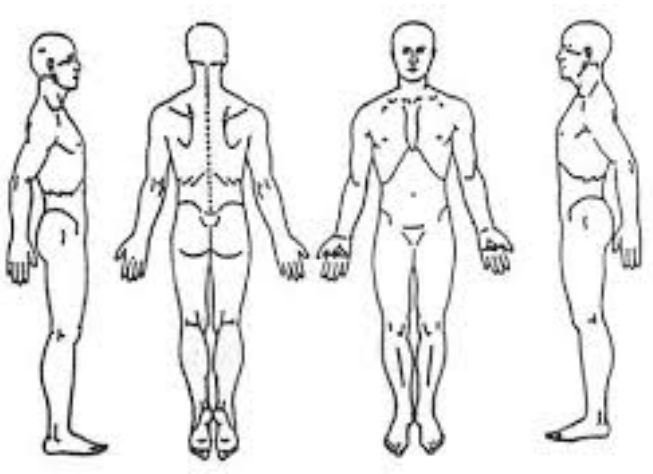
Are your symptoms getting: ☐ Better ☐ Worse ☐ Unchanging

Please rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If you have pain, rate the intensity on the scale below:



Please circle the approximate location of your symptoms:



What types of treatment, if any, have you tried for this problem in the past?:

Do you use: ☐ Braces ☐ Splints ☐ Stander ☐ Walker ☐ Wheelchair

Explain:

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Social History

Who does your child live with?:

What school or daycare does your child attend? What hours of the day?:

What physical/extracurricular activities does your child participate in?:

Does your child exhibit any additional behaviors/conditions that concern you? Explain:

Emergency Contact Name: Telephone #

Emergency Contact Name: Telephone #

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Attendance Policy

1. Regular attendance is required of all clients scheduled. Patients will not benefit from sporadic intervention
2. Clients 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/Guardian's Signature Date

Therapist Responsibility to the 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 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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Consent to Treat and HIPPA Authorization

Patient's Name_____ Date of Birth_____
(Please Print)

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

1. Pediatric Therapy Associates, LLC and its employees/contractors are authorized to use or disclose health information that is pertinent or required for therapy purposes.
2. I understand that Pediatric Therapy Associates, LLC may 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 multiple disclosures by the individual or facility receiving the information.
3. I may revoke this authorization by notifying Pediatric Therapy Associates, LLC in writing. However, I understand that any action taken previous to revocation of this authorization cannot be reversed, and my revocation will not affect those actions. The authorization expires when a patient is discharged by Pediatric Therapy Associates, LLC or when written notice to revoke authorization is received. Prior notification will be given to the parent or guardian before information is released.
4. I do hereby give my consent for speech, occupational, and physical therapy according to the guidelines established by the referring physician and the therapist. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of sensitive nature.
5. I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I haven been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
6. I know and agree that Pediatric Therapy Associates, LLC is not responsible for loss or damage of personal valuables.

_____ _____
Parent /Guardian Signature Date

_____ _____
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 Associates, 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 Associates, 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 Associates, 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 Associates, 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 Associates, 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) _____

_____ _____

Parent /Guardian Signature Date

_____ _____

Therapist's Signature Date