PediatricTherapy Associates

181 Town Creek Rd.
Aiken, SC 29803
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F: (803) 642-0588

714 South Lake Drive STE 150
Lexington, SC 29072
P: (803) 356-4782
F: (803) 996-4782

PATIENT INFORMATION

Patient Name: _____ Nickname: _____ DOB: _____

Age: _____ □ Male □ Female Social Security Number: _____

Legal Guardian #1: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary (Cell) Phone #: _____ Secondary Phone #: _____

Marital Status: □ Single □ Divorced □ Married □ Widowed

Occupation: _____ Employer: _____

Legal Guardian #2: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary (Cell) Phone #: _____ Secondary Phone #: _____

Marital Status: □ Single □ Divorced □ Married □ Widowed

Occupation: _____ Employer: _____

EMERGENCY CONTACT #1: _____
PHONE: _____ RELATIONSHIP: _____

EMERGENCY CONTACT #2: _____
PHONE: _____ RELATIONSHIP: _____

INSURANCE INFORMATION-Please complete below information.

Policy Holder Name: _____ Relationship to Patient: _____

Birthdate: _____ SSN: _____ Employer: _____

Address: _____ 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

_____

Print Name of Patient, Parent, Guardian, or Person Responsible

Who does your child reside with? _____ Who has custody of your child? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person:
_____ **Phone: _____**

Do you allow us to discuss your child's information with that person? □ Yes □ No

Preferred Language: □ English □ Spanish □ Other: _____

Social History

Is your child adopted? □ Yes □ No Is your child aware of the adoption? □ Yes □ No

Siblings/Others living in the home:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Referral Sources

Referring Physician: _____ Primary Physician: _____

Please list any additional specialists/services that your child has received.

Service	Name of Specialist/Agency	Phone Number
School/Daycare		
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Early Interventionist		
Neurologist		
Gastroenterologist (GI)		
Cardiologist		
ENT		
Orthopedist		
Ophthalmology/Vision		
Dentist		
Other		

Pregnancy & Delivery □ Full Term □ Premature (number of weeks at birth) _____

□ Vaginal/Natural Delivery □ C-section delivery

Medications taken during pregnancy: _____

Complications during Pregnancy: _____

Any birth complications: □ Yes □ No If yes, explain: _____

_____

Length of hospital stay after birth: _____ (circle one) Days Weeks Months

Did patient require any of the following at birth? □ Oxygen □ Tube Feedings □ Transfusions □ Ventilator

Medical History

Are immunizations up to date? □ Yes □ No

List any medications your child is currently taking: _____

_____

Does your child have any allergies? □ Yes □ No What kind? □ Drug □ Food □ Latex □ Other

List Allergens:_____

Does your child require an EpiPen? □ Yes □ No

Check conditions that apply:

	Yes	No		Yes	No
Acid Reflux			Epilepsy/Seizures		
ADD or ADHD			Feeding Tube Placement		
Asthma			Hearing Impairment		
Autism			Learning Disability		
Cerebral Palsy			Neurological Disorder		
Cognitive deficits			Traumatic Brain Injury		
Congenital Heart Defect			Vision Impairment		
Down Syndrome			Other:		

Has your child had any of the following? Check all that apply.

□ Surgeries □ Accidents □ Injuries □ Hospitalizations □ Chronic Ear Infections

Explain: _____

_____

Pain (Complete if applicable)

Does your child experience any pain currently? □ Yes □ No

Describe your symptoms: _____

Has your child had any X-rays? □ Yes □ No If yes, what was the date: _____

Has your child had an MRI? □ Yes □ No If yes, what was the date: _____

Developmental History (**Please complete if applicable.***)

1. Language Development- Does your child exhibit the following?

	Yes	No		Yes	No
Responds to his/her name			Uses words for communication		
Produces Vocalizations			Combines words for communication		
Points to objects/pictures			Difficulty producing speech sounds		
Follows simple directions			Age appropriate vocabulary		
Understands simple commands					

2. Feeding History

□ Bottle fed □ Breast fed □ Tube fed □ Finger feeds □ Uses utensils

Does your child exhibit any of these? □ Picky Eater □ Choking □ Coughing □ Drooling

□Vomiting after or during meals □ Reflux □ Sucks fingers/thumb or pacifier

3. Gross Motor Skills – Did your child do the following?

	Yes	No		Yes	No
Rolling over			Jumping		
Sitting alone			Running		
Crawling			Climbing Stairs		
Walking			Plays on slide/swing		

4. Fine Motor/Self-Care Skills- Did your child do or is currently doing the following?

	Yes	No		Yes	No
Scribbling/Coloring			Dressing self		
Copying			Tying shoe		
Buttoning			Toilet trained		
Zipping			Feeds self with utensils		
Cutting			Drinks from a cup		

5. Sensory/Emotional/Behavioral -Please check all that apply.

Difficulty attending to tasks		Difficulty sleeping	
Rocks while sitting		Avoids touching messy things	
Bangs head/Hand flapping		Mouths non-food objects	
Easily frustrated		Sensitive to sounds	
Resistant to changes		Always “on the go”	
Does not like feet off the ground		Difficulty separating from primary caregiver	
Picky eater		Has no fears	
Difficulty interacting with peers/adults			

6. Additional speech/language/motor skills:

	Yes	No		Yes	No
Child able to write full name			Appropriate topic maintenance		
Handwriting Difficulties			Answers various “wh” questions		
Difficulty completing self-care tasks (dressing, grooming, etc.)			Understands complex sentences/paragraphs		
Difficulty carrying on conversation with others			Appropriate interaction with peers/adults		
Label/exhibit emotions			Understands figurative language		
Understands appropriate voice/tone			Demonstrates safety awareness		

Additional Concerns: _____

_____

_____

_____

_____

_____

CONSENT TO TREAT & HIPAA AUTHORIZATION

Child's Name: _____ DOB: _____
(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 do authorize Pediatric Therapy Associates including therapists and other qualified personnel, including appropriately supervised students and residents, to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgement of the medical professional. I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.
3. 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.
4. I may revoke this authorization by notifying Pediatric Therapy Associates, LLC in writing and understand that any action taken prior to revocation of this authorization cannot be reversed, and my revocation will not affect those actions. The authorization expires when a patient is discharged from 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.
5. 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 potentially leading to redness of the skin.
6. I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so.
7. I have been made aware and understand that Pediatric Therapy Associates, LLC is not responsible for loss or damage of personal valuables that I, or anyone accompanying me, may bring to Pediatric Therapy Associates' facility.
8. PHOTOGRAPHY/VIDEO:
    a. I acknowledge that my child's photograph may be taken for evaluation purposes and is the property of PTA unless I withdraw my consent in writing. I consent to photographing, videotaping, and/or video monitoring, including appropriate portions of the body, solely for medical and medical documentation purposes only, provided said photographs or video tapes are maintained and released in accordance with protected health information regulations.
    b. I understand and agree not to photograph, videotape, record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.
9. CELLPHONE USE: I hereby consent to provide my telephone number(s) including cellphone number, so that Pediatric Therapy can contact me in any manner including but not limited to by manually placing a call, text messaging, or using an automatic text messaging system regarding any manner, including but not limited to your child's medical treatment, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information I may provide. I understand that I will be able to change my preference at any time.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date

ATTENDANCE POLICY

Attendance Policy

Consistent attendance is required for all clients and is crucial to your child's progress in therapy. Patients do not benefit from sporadic attendance. Pediatric Therapy strives to provide the best therapy services possible and will adhere to the following guidelines for client attendance in therapy.

1. Two no-show or three cancellations may result in the removal of reoccurring appointments or discharge from therapy services. Appointments with different disciplines on the same day count as separate appointments.
2. Therapy appointments should be cancelled within a 24-hour period (when possible). Voicemail is available 24 hours a day. Please state reason for cancellation when leaving a voicemail.
3. All scheduling needs should be addressed with **front office administrator only** such as rescheduling or cancelling an appointment.
4. Any patient who is more than 15 or more minutes late for a scheduled appointment may be asked to reschedule their appointment.
5. Caregivers are able to observe sessions as desired but are not required to unless requested by therapist for therapeutic educational purposes. Caregivers that choose to leave the premises during their child's therapy session are required to be back on the premises no later than 10 minutes prior to end of treatment session to allow for therapist's to review your child's session and provide you with activities to carryover at home.

Cancellation Policy

Pediatric Therapy Associates has a 24-hour cancellation policy. Please notify our office if you unable to make your appointment within 24 hours of scheduled appointment. If you cancel an appointment in less than 24 hours of scheduled appointment, it will count as a no show for that day.

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist Signature Date

FINANCIAL POLICY

Any payments, co-payments are due at time of each visit for charges incurred up through your last visit. We accept cash, checks, credit/debit cards, FSA, HSA. **Please understand that you are financially responsible for all charges, whether or not they are paid by insurance.**

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days form the date of service, you agree to make arrangement for prompt payment.
2. Should your insurance coverage change, our office should be notified within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account and all future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.
3. Our fees are generally considered to fall within the acceptable range by most insurance carriers and therefore are covered up to the maximum allowance determined by each carrier. This applies to the companies who pay a percentage (such as 50% or 80%) of the usual, customary, and reasonable rate (UCR). This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. Please note insurance companies may indicate the services were not medically necessary and claim that, because Pediatric Therapy Associates is a preferred provider, you do not have to pay the balance. This is NOT the case and you will be billed for services. This office cannot accept responsibility for negotiating settlements on disputed claims.

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you!

Assignment of Insurance Benefits

_____ I authorize and direct that any insurance proceeds payable for services provided to patient by Pediatric Therapy Associates, LLC be paid directly to Pediatric Therapy Associates, LLC and hereby assign to Pediatric Therapy Associates without recourse, all interest and rights to claim, collect, and receive said proceeds from insurance company providing coverage for these products and services. I authorize any and all insurance companies to yield to Pediatric Therapy Associates any and all information pertaining to patient's insurance benefits and the status of claims submitted by Pediatric Therapy Associates.

Some or all services provided to patient by Pediatric Therapy Associates may be covered by insurance. It is your responsibility to be aware of your insurance benefits. **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.**

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 to insurance.

Private Insurance Patients

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

If you have any further questions, please contact our billing department at 803-753-4665.

Patient Name (please print): _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist Signature Date