PEDIATRIC THERAPY ASSOCIATES

OFFICES OF HANDS-ON THERAPY, INC. ~ PRYOR PHYSICAL THERAPY, INC. ~ SPEECH SOLUTIONS, INC.
2302 Llama Drive, Searcy, AR 72143 ~ Phone: (501) 268-5001 ~ Fax: (501) 268-5443

Patient Information

Today's Date:_____
Patient's Name:_____ Please Circle: *MALE* *FEMALE*
Patient's Address:_____ City_____ State____ Zip_____
Primary language used at home_____ Date of Birth_____ SSN#_____
Primary Care Physician:_____

Mother's Name:_____ DOB_____ SSN_____ Age: ___
Address:_____ City_____ State_____ Zip_____
Phone _____ Permission to Text: Yes____ No____
Occupation_____ Employer_____

Father's Name:_____ DOB_____ SSN_____ Age: ___
Address:_____ City_____ State_____ Zip_____
Phone _____ Permission to Text: Yes____ No____
Occupation_____ Employer_____

Please list others living with child (Name, sex and age of each)
_____ _____
_____ _____
_____ _____

Emergency Contact (not living in same household)
Name: _____ Phone:_____
Relationship:_____

Patient's Private Insurance Information

****Any additional insurances can be added to the back****

Name of Insurance Company_____
Insured's Name_____ Insured's DOB_____
Policy or ID# _____ Group #_____

Medicaid

Medicaid Number_____
Full Name Listed on Medicaid_____

Photo Consent

_____**I give my consent that photos of my child can be taken/stored/ posted for our Pediatric Therapy Clinic &/or Pediatric Therapy social media pages. I understand that if patients are identified, only their first name is used.**

I certify that I have provided accurate information and answered all questions on this form truthfully to the best of my knowledge.

Parent/Guardian Signature:_____

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Patient's History

Medical problems during pregnancy? (Describe) _____
_____

Child was born at: _____weeks Weight: _____lbs._____oz. Labor induced?_____

Child's health at birth: (NICU, Oxygen, etc.) _____
_____

Past Hospitalizations or Surgeries
_____

High Fevers (104 ◦F or higher) Yes/No Duration:_____

Medications:_____
_____
_____

Allergies/Dietary Concerns:
_____
_____

Hearing/Vision Test

Has your child had his/her hearing tested? Yes/No
If yes, please circle the result: Pass/Fail
Date of screening: _____
Has your child had his/her vision tested? Yes/No
If yes, please indicate the results: _____

General Developmental and Social History

Please list the age at which your child has met the following developmental milestones, if applicable:

Babble (use of consonants): _____
Sit without support: _____
Crawl: _____
Pull to stand: _____
Walk: _____
Single word use (*no, mom*) _____
Feed self: _____
Potty-trained: _____ Bladder: Yes/No Bowel: Yes/No Dry at night: Yes/No
Smile: _____
Does your child use (please circle)
Single words: Yes/No Phrases: Yes/No Sentences: Yes/No Say words clearly: Yes/N

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Has your child been diagnosed or treated for: (please circle)

ADD/ADHD: YES/NO	Allergies: YES/NO	Asthma: YES/NO	Trauma: YES/NO
Cancer: YES/NO	Cleft Palate: YES/NO	Cerebral Palsy: YES/NO	Other: YES/NO
Diabetes: YES/NO	Head Injury: YES/NO	Ear Infections: YES/NO	
Operation: YES/NO	Seizures: YES/NO	Tubes in ears: YES/NO	

If "YES" to any of the above, explain:

_____

_____

Please describe your child's personality: (activity level, affectionate, shy, noisy, fearful, etc)

_____

_____

_____

Describe the areas of concern for your child's development:

_____

_____

Is there any additional information that might be helpful in the evaluation or therapy process? _____

_____

Does your child attend: (please circle) School/Grade Daycare Both
If so, please list name of school and/or daycare:

_____

Check any of the following with whom you have had contact concerning your child:

- Pediatrician _____
- Ear, Nose & Throat Specialist_____
- Ophthalmologist/Audiologist_____
- Speech Pathologist _____
- Occupational Therapist _____
- Physical Therapist_____
- Social Worker/Certified Case Manager _____

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Feeding Concerns

Does your child have any feeding concerns? Yes/No.
If yes, please continue with the rest of the page.

Was your child?
Breastfed: YES/NO
Bottle-fed: YES/NO
Both: YES/NO
Describe any problems encountered: _____

_____

Type of bottle(s) used: _____
Does your child currently take a bottle: YES/NO

Has your child transitioned to a cup: YES/NO
Type of cup(s) used: _____

Transition to solids: check all consistencies attempted
____ Smooth purees
____ Lumpy purees
____ Dissolvable solids (ex: puffs, rusks)
____ Soft solids
____ Dense solids (meats, vegetables)
Describe any problems encountered: _____

_____

List foods that your child refuses/has difficulty eating: _____

_____

Check all that apply:
____ Choking/gagging while eating
____ Vomiting after eating
____ Pocketing food (holds or stores food in their mouth)
____ Loss of food while eating
____ Loss of liquid while drinking
____ Has had swallow study performed: Y/N
If yes, please describe results: _____

_____

- Does your child have poor weight gain (dropping percentiles on the growth curve) or weight loss? YES/NO
- Does your child have a food range of fewer than 20 foods? Especially if foods are being dropped over time without new foods being added to replace them? YES/NO

Any other feeding concerns? _____

_____

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Service Fee Agreement

I hereby authorize Pediatric Therapy Associates: offices of Hands-On Therapy, Pryor Physical Therapy and/or Speech Solutions to furnish information to insurance carriers concerning my child's illness and treatment. I authorize and request my insurance company to pay directly to Hands-on Therapy, Pryor Physical Therapy, and/or Speech Solutions otherwise payable to me. I understand and agree that it is my responsibility to know my insurance coverage.

Private Insurance

_____ I understand that while my insurance may confirm my benefits, **confirmation of benefits is not a guarantee of payment.** I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

_____ I understand and agree that I am responsible for any copays, coinsurance or deductible amount upon processing of insurance.

_____ I agree to pay $100 for the evaluation and $50 per treatment visit at the time that services are rendered until insurance has processed. At that time Pediatric Therapy Associates will inform the parent/guardian of any financial changes going forward.

Self-Pay

_____ I agree to pay $150 for the evaluation and $100 per treatment hour at the time that services are rendered.

Outstanding Balances

_____ I understand that at any time a balance exceeds $500 per discipline, services will be placed on hold immediately. If 50% of the outstanding balance is paid within 2 weeks of notice, services may resume as scheduled. If 50% of the outstanding balance is *not* paid, your child will be placed on a waiting list and your current appointment time may not be available if/when services resume.

Medicaid

_____ I agree to inform the office of any changes in my insurance coverage. If my insurance is terminated at the time of service, I agree that I am financially responsible for the balance in full.

I understand and agree that I am financially responsible for all charges for services rendered.

_____ _____

Parent/Guardian Signature Date

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your/your child's Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your/your child's records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, you may contact this office in writing at 2302 Llama Drive, Searcy, AR 72143.

1. The patient/guardian understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient/guardian agrees to allow the office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient/guardian for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient/guardian has the right to examine and obtain a copy of his/her health records at any time and request corrections. The patient/guardian may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI.
3. A patient's/guardian's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient/guardian may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients/guardians have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient/guardian refuses to sign this consent for the purpose of treatment, payment and health care operations, the occupational therapist, physical therapist, and/or speech therapist has the right to refuse to give care.
8. The patient/guardian understands that Occupational, Speech and Physical Therapy students may observe and/or participate in therapeutic intervention during your child's treatment sessions. Parent/guardian gives permission for observation/therapeutic intervention by therapy students. All therapy students abide by PHI procedures and have signed a statement as to such.

I have read and understand how my/my child's Patient Health Information will be used, and I agree to these policies and procedures.

NAME OF PATIENT DATE

SIGNATURE OF PATIENT/GUARDIAN DATE

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HIPAA Privacy Authorization Form

Authorization to Discuss Protected Health Information

Patient's Legal Name_____

Birth date ___/____/_____

I_____ authorize Pediatric Therapy Associates to share pertinent "protected information" with my immediate family members or significant others, as noted below.

_____	_____	_____
First Name, Last Name	*Relationship*	*Best Contact Number*
_____	_____	_____
First Name, Last Name	*Relationship*	*Best Contact Number*
_____	_____	_____
First Name, Last Name	*Relationship*	*Best Contact Number*
_____	_____	_____
First Name, Last Name	*Relationship*	*Best Contact Number*
_____	_____	_____
First Name, Last Name	*Relationship*	*Best Contact Number*

I understand I can withdrawal the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other does not disclose or use the information in any way without discussing with me first.

_____ _____

Signature of patient or authorized person Date

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ATTENDANCE AND CANCELLATION POLICY

In order to better serve your child and make quicker progress toward goals, regular attendance to therapy is imperative. The most common cause of lack of progress is inconsistent attendance. Missed appointments affect everyone, including your child, our skilled staff, and other clients in need of our treatment. When clients do not show for their appointment or give adequate cancelation notice, we do not have the opportunity to reschedule with another client who is in need of an appointment.

Please thoroughly read and initial next to your responsibilities outlined as follows:

_____ I am responsible for attending therapy sessions as scheduled, I understand that I must maintain at least an **80% attendance rate** or risk losing my appointment slot. Appointments cancelled by the clinic will not be included in missed sessions.

_____ In the event of a cancellation, I will provide as much notice as possible. Non-emergency cancellations require at least 24-hour notice and may include: vacations, pre-planned medical appointments, family events, sports events, lack of childcare, or anything that is not designated as emergency. “Emergency” cancellations are accepted only for illness (fever within the last 24 hours, unidentified rash, diarrhea, vomiting, or any highly contagious illness), illness of a family member, or death in the family. In the event of an emergency cancellation, I understand I still must notify the clinic on the day of the appointment. (Emergency and non-emergency cancellations are both included in the 80% attendance rate)

_____ If a patient is absent and does not call to cancel **two times** in a 3-month period, it may result in losing the patient’s weekly appointment slot and being moved to a cancellation call list.

_____ I understand that Pediatric Therapy Associates, Inc **may** send text reminders for ongoing standing appointments, as a courtesy. I recognize that **my attendance is not dependent upon the receipt of any reminders.**

The phone number below is my preferred number for receiving courtesy appointment reminders:
Phone number: _____

I have read, understand, and agree to Pediatric Therapy Associates, Inc Attendance and Cancellation Policy as outlined above.

Name of Patient: _____

Parent or guardian Printed Name: _____

Parent or guardian Signature: _____

Relationship to patient: _____ Date: _____