

ABC Pediatric Therapy Network

ABC Pediatric Therapy Network Patient Information Form

Date: _____

Child's Full Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Diagnosis: _____

Child's Address: _____ City: _____ State: _____ Zip: _____

Guardian Name (1): _____

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

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____

Guardian Name (2): _____

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

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____

Referring Physician/Pediatrician (Name and Facility): _____

Physician Phone Number: _____ Physician Fax Number: _____

Insurance Company (list primary and secondary): _____

Insurance Company ID number (list primary and secondary): _____

Coverage: How many visits will insurance cover for your child to receive per year for the following disciplines)?

Physical Therapy: _____ Occupational Therapy: _____ Speech Therapy: _____

The following is to be filled out by the evaluating therapist, if therapy is recommended:

PT OT ST Billing Diagnosis: _____

Anticipated duration of treatment in order to meet long term goals: _____

Number of times per week recommended: _____

Estimated end date for insurance coverage: _____

Additional therapy options recommended:

_____ Private Pay _____ Group Treatment _____ Summer Camp _____ Other _____

The family has been informed of the following alternative funding options:

_____ Family Resources _____ BCMH _____ School Therapy _____ Help Me Grow

_____ PASSS _____ Autism Scholarship _____ Building Blocks _____ Other: _____

Therapist has discussed long term plan of care/annual plan of care with the family on (date): _____ Initials: _____

Annual Evaluation and re-evaluation dates:

Comments/Precautions: _____

ABC Pediatric Therapy Network

Individualized Needs Assessment

Child's name _____ Date of Birth _____

Name of person completing this form: _____

Relationship to child: _____

Is your child adopted? _____

Birth History

Child was born: ___ full-term or ___ premature; If premature, how many weeks? _____

Delivery: ___ vaginal ___ with forceps ___ C-section

Were there any complications? _____

Was your child placed in the Newborn Intensive Care Unit? ___ If so, how long? _____

Please describe any other medical problems or complications at birth.

Developmental History

Please indicate at what age your child achieved the following milestones:

*Mark N/A for those which your child has not achieved yet

Rolled over _____

Babbled _____

Sat alone _____

Said first word _____

Crawled _____

Drank from a cup _____

Pulled to stand _____

Used spoon _____

Stood alone _____

Toilet trained _____

Walked alone _____

Dressed self _____

Current physical limitations: _____

Comments: _____

Medical History

Current diagnosis: _____

Hospitalizations: ___ No ___ Yes; If yes, please describe _____

Surgeries: ___ No ___ Yes; If yes, please list _____

Previous psychological evaluation? ___ No ___ Yes; If yes, please describe _____

Current physician(s): _____

Medications: _____

Special equipment your child uses: Splints ___ Braces ___ Adaptive utensils ___ Other _____

Any feeding problems or nutritional concerns? _____

Please check all that apply to your child:

Trach ___ Allergies (list below) ___ Hearing aids ___ Wears glasses ___

C-Line ___ Latex sensitivity ___ Hearing difficulty ___ Vision problem ___

G-tube ___ Seizures ___

Comments: _____

ABC Pediatric Therapy Network

Caregiver Concerns

What are your main concerns with your child?

What are your child's strengths?

Has your child received occupational therapy, physical therapy, or speech therapy before? Y / N

If yes, please indicate which services and for how long: _____

Educational Information

School/Educational program currently attending: _____

Present grade level: _____

Special services received in school: _____ OT _____ PT _____ Speech

Does your child receive any of the following?

Special Education _____ Behavior Intervention _____ Other special service _____

Does your child's teacher have concerns with your child's development in any of the following areas?

Motor skills _____ Social abilities _____ Self-help skills _____ Learning abilities _____

Comments: _____

Social/Emotional Development

Does your child interact well with others? _____ Yes _____ No

Does your child have any trouble making friends? _____ Yes _____ No

Fears, Coping behaviors: _____

Does your child have difficulty calming himself/herself when upset? _____ Yes _____ No

Additional comments: _____

Behavior

Please check any of the following that apply to your child:

- | | | | |
|---------------------------------|-------|-------------------------------|-------|
| Cries often | _____ | Dislikes hair brushing | _____ |
| Frequent temper tantrums | _____ | Dislikes tooth brushing | _____ |
| Anxious | _____ | Avoids touch from others | _____ |
| Trouble following directions | _____ | Dislikes playground equipment | _____ |
| Trouble with changes in routine | _____ | Seems to be "on the go" | _____ |
| Clumsy | _____ | Rocks self | _____ |
| Weak muscles | _____ | Sensitive to light | _____ |
| Picky eater | _____ | Sensitive to sound | _____ |
| Mouths objects | _____ | Poor attention span | _____ |

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Signature

Date

ABC PEDIATRIC THERAPY NETWORK

Specializing in pediatric OT, PT, and Speech Therapies

9902 Windisch Road • West Chester, OH • 45069

Phone: (513) 755-6600 • Fax: (513) 755-3762

Release of Information Form

Child's Name _____ Birth date _____

Guardian/s _____

Address _____ City/State _____

Zip Code _____ Phone Number _____ Date _____

- I. I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, _____ (child's name) to ABC Pediatric Therapy Network. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I authorize ABC Pediatric Therapy Network to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

Signed _____ (guardian)

- II. I hereby authorize ABC Pediatric Therapy Network to release therapy reports regarding my child, _____ (child's name), to my child's physician, and any clinic, hospital, institution, insurance company, school, and other: _____. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

Signed _____ (guardian)

This consent will expire in 180 days (6 months) or after all billing issues related to this treatment will have been resolved.

ABC Pediatric Therapy Network

Emergency Medical Form

Child's Name _____

Allergies _____

Medical
Precautions _____

Contact Person in case of emergency _____

Phone: _____

2nd Person: _____

Phone: _____

Our policy is to call 911 in the case of any medical emergency. Please indicate if you would like us to do otherwise, and what action you would like taken:

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

ABC Pediatric Therapy Network

Permanent Schedule Request

Patient Name: _____ DOB: _____

Date of Evaluation: _____ Circle: PT OT Speech

Guardian: _____

Phone #: Home _____ Cell: _____

Email: _____

please provide the best numbers where you can be reached

Days and Times Available: (please include full blocks of time)

Example: Monday from 9:00-3:00 or anytime after 2:00

the more flexible you are, the quicker you will get a permanent spot

Mon _____ Tues _____ Wed _____

Thurs _____ Fri _____

Will you schedule week to week until a permanent appointment is found?

Yes

No

Concerns or questions about scheduling:

It is important to us that you receive the best care for your child. Thank you for your patience during this scheduling process and for trusting us with the care of your child.

ABC Pediatric Therapy Network

**ABC Pediatric Therapy Network
Insurance Information**

Child's Name: _____ DOB: _____

Guardian's Name: _____

Primary Insurance:

Policy Holder's Name: _____ DOB: _____

SSN: _____ Employer: _____

Insurance Company: _____

Insurance Company Phone: _____

Insurance Company Address: _____

ID#: _____ Group #: _____

Secondary Insurance: (if applicable)

Policy Holder's Name: _____ DOB: _____

SSN: _____ Employer: _____

Insurance Company: _____

Insurance Company Phone: _____

Insurance Company Address: _____

ID#: _____ Group #: _____

Assignment of Payment

Authorized person's signature: I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to ABC Pediatric Therapy Network. A photocopy of this assignment is to be considered as valid as an original. I authorize ABC Pediatric Therapy Network to release information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize ABC Pediatric Therapy Network to receive direct payment for therapy services rendered to my child.

Signed _____ Date _____

ABC Pediatric Therapy Network

REIMBURSEMENT POLICY

As has always been our policy, the family is responsible to call their insurance company and be aware of their benefits. They are responsible to pay out of pocket fees at the time of service. Families need to keep track of the number of visits or when precertification is necessary. The number of visits and the payment of all claims is the responsibility of the family and not ABC Pediatric Therapy Network.

ABC Pediatric Therapy Network will call your insurance company, in addition to your call, to verify benefits. This is not proof of insurance or payment! We also track the number of visits, but it is not our responsibility. Errors made on our count will be the responsibility of the family.

ABC Pediatric Therapy Network, as a benefit to our clients, will submit claims to your insurance. This again is not our responsibility, but it being provided as a benefit to you.

Unpaid claims are called on by ABC at least every 30 days.

Families should call at least monthly to be sure claims are received and being processed.

Effective March 1, 2004, after 60 days, ABC will inform the parents of unpaid claims.

After 90 days without payment, the family will be responsible to begin paying on their account balance and private pay future appointments in order to remain on the treatment schedule.

If a claim has been denied and is going through the appeals process, the family must begin paying on the balance and private paying any new treatment sessions.

Much of this can be avoided by knowing your policy and following up on your claims. The bills are ultimately your responsibility. ABC is only required, once treatment is provided, to give you the information to get reimbursed from your insurance company. Submitting the claims is not our responsibility, but a benefit to you.

Please help us to keep our costs down and to continue to provide the best quality care possible.

Thank you for your help in this matter.

ABC Pediatric Therapy Network

Signature of Guardian: _____

ABC Pediatric Therapy Network

Attendance Policy

Scheduled Appointments:

- Please arrive for each appointment in time to check-in and begin therapy at the scheduled time
- A late fee of \$15 may be assessed if you are 10 or more minutes late for your appointment. If there is a difficulty getting to your appointment, please discuss this with the front desk so we can recommend another appointment time.
- If you leave during your child's therapy session, we request that you return 15 minutes prior to the session being complete to enable the therapy to discuss your child's progress
- If you are more than 10 minutes late for your appointment, the therapist may choose not to keep the session due to limited time constraints, please make sure you are on time and ready for your appointment

Cancellations:

- If you must cancel an appointment due to illness or emergency, contact our office **24 hours** before the scheduled appointment or a \$25 fee may be assessed. Our office staff will then ask for your availability to reschedule the appointment.
- Please verify with the front desk any appointments that will be cancelled due to a vacation. We request to receive this information at least 7 days prior to the date which will be missed. Currently, we are unable to hold any time more than 2 consecutive weeks due to a vacation.
- In the event of inclement weather, contact our office the day of the event if you are unable to make it to your appointment. A fee will not be assessed, but the missed appointment will be documented.
- Frequently cancelled appointments (more than 1 cancelled visit for every 8 visits scheduled) will be basis for removal from our permanent schedule and allow you to only schedule on a week to week basis.

No Shows:

- Failure to cancel or to appear during an appointment is considered a "no show." A \$25 fee will be assessed. Please contact our office immediately to discuss future appointments.
- If two "no shows" occur, your child's appointment time will be automatically offered to another child waiting for services.

A Note from the Therapists:

We expect for you to make every effort possible to attend your scheduled appointments. When we establish a plan of care for your child, we base our goals on the child having consistency. If your child misses appointments, they will not meet their goals as quickly, and your child will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. IN the event that you do have to cancel, we strongly encourage you to reschedule, even if it is with another therapist. We actually enjoy when another therapist sees one of our patients because it gives us another opinion of ideas for your child. We are always in close communication with each other. Any other concerns you may have regarding your child, please discuss this with your therapist.

I have read the attendance policy and understand the attendance expectations for my child.

Parent/Guardian Signature

Date