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Patient Information:

Child's full name:_____ _____ Date of Birth:_____ Age: _____ Sex: ○M / ○F

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

Is the patient a foster child? _____ Yes _____ No

Case Worker Name:_____ _____ Phone:_____ County:_____

Additional information regarding care, contact, and restrictions: _____ _____ _____

Guardian Information:

Guardian's Name (1): _____ _____ _____ _____

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

Home Phone: _____ Cell Phone:_____ Work Phone: _____ _____

E-mail:_____ _____ _____

Guardian's Name (2):_____ _____ _____

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

Home Phone: _____ Cell Phone:_____ Work Pone:_____

E-mail: _____ __

Doctor Information:

Physician/Pediatrician (Name and Facility): _____ _____

Physician Phone Number: _____ _____ Physician Fax Number: _____

Insurance Information:

** Please list ***all*** insurance plans for which the patient is a beneficiary, **even if you know that therapy will not be covered by this plan.**

Please note: If your child is covered by **Care Source, Buckeye Community Plan, Molina, UHC Community Plan, Paramount, or Medicaid: Please include any and all commercial insurance policies that list your child as a beneficiary (i.e. Anthem, United Healthcare, Medical Mutual) in order to ensure that claims are processed appropriately.

Primary Insurance:

Policy Holder's Name:_____ _____ DOB:_____

SSN:_____ Employer:_____

Insurance Company Name & Address: _____ _____

Phone : _____ _____ ID# :_____ Group # :_____

Secondary Insurance (if applicable):

Policy Holder's Name:_____DOB:_____

SSN:_____ Employer:_____

Insurance Company Name & Address: _____ _____ _____

Phone:_____ _____ ID# :_____Group # :_____

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Release of Information Form

Child's Name_____ Date of Birth _____ _____

This form allows ABC Pediatric Therapy Network to send and receive EVALS, reports, and other requested information, including sending claims to your insurance provider. If we do not have this form filled out, we will not be able to provide this service on your patient's behalf.

I hereby authorize any physician, clinic, hospital, institution or school to release Medical and Psychological information regarding my child, (Patient'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 also authorize ABC Pediatric Therapy Network to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

I hereby authorize ABC Pediatric Therapy Network to release therapy reports regarding my child, (Patient's Name) _____, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of _____. 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.

(OPTIONAL)

I give my permission for ABC Pediatric Therapy Network to photograph and/or videotape my child, and use said photos/videos for promotional or teaching purposes.

☐ Agree

☐ Disagree

Parent/Guardian Signature _____ _____

The release of information consent will expire in 1 year or after all billing issues related to this treatment will have been resolved. This consent may be revoked at any time through a written request to ABC Pediatric Therapy Network.

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Patient Billing Acknowledgement Form
Maintenance/Elective Care

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

Provider

Services to be provided are listed below:

Occupational Therapy, Physical Therapy and Speech Therapy including but not limited to all necessary services/supplies associated with therapy treatment.

Time Frame from January 1, 2018 through December 31, 2018.

Plan of care determined by therapist and family.

Provider Signature: Shelly Clawson

I acknowledge that I have been told in advance by my provider that the services/products listed above may or may not be covered by my Health Plan. I agree to pay for any non-covered services.

Parent/Guardian Signature _____ _____

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HIPAA Release of Information AUTHORIZATION FORM

I hereby authorize ABC Pediatric Therapy Network and its affiliates, its employees and agents , the ability to send me electronic communication containing my personal health information maintained (such as information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, Member ID number, payment arrangements and balance information) except the following information about me: _____ _____ _____[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of: helping me to resolve claims, or health benefit coverage issues, and the purpose of communication regarding plan of care.

I also allow the ABC staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of the child.

I understand that the electronic communication will be sent via an unsecure/unencrypted email network.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date listed below for one year.

I understand that I have a right to revoke this authorization by providing written notice to ABC Pediatric Therapy Network. However, this authorization may not be revoked if ABC Pediatric Therapy Network, its employees or agents have taken action on this authorization prior to receiving my written notice.

I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Parent/Guardian Signature _____

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Notice of Privacy Practices and Confidentiality Agreement

**This Notice describes how health information about your child may be used and disclosed and how you can get access to this information.

The federal government has legislated the Health Information Portability and Accountability Act (HIPAA). The new rules regulate the privacy and accessibility of health information regarding your child's care at ABC Pediatric Therapy Network. We must follow these privacy practices that are described in this notice until it is changed. Effective 4/14/03. You may request a copy of your notice at any time as applicable by law. Any changes will be added to this form will be available to you. You may request a copy of this at any time.

Use and Disclosure Information

Treatment - We may use or disclose your child's health information to plan a course of treatment that includes evaluation, goals and treatment approach. At times, your child's medical information may be reviewed by a student intern at our facility. In addition, your child's medical records will be provided to your health plan and consulting physicians. Your child may receive therapy services in the same room with another child. Within an ABC facility, your child's goals and data pertinent to your child's treatment may be discussed with others.
Payment - We may use and disclose your health information to obtain payment for services we provide to you/your family member. A bill may be sent to you or your health insurance payer. The information on the bill may obtain information that identifies you, your spouse or your child. This information may include the child's date of birth, diagnosis and procedures or supplies used.
Appointments - We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards or letters).
Check-In - Your child's name may be called when checking in at our window.
Schools and Agencies - We may provide information requested for IEP's, MFE's and evaluations with other professionals. We may disclose your child's information to doctors and other health professionals in regards to your child's care with us.
Other Permitted Uses and Disclosures - We may share information with other public health authorities charged with preventing or controlling disease, injury or disability. We will notify appropriate persons if we suspect child abuse or neglect.

We may need to provide medical information regarding your child to legal/judicial/administrative and law enforcement person. We may need to send you information regarding your child's care or billing issues through the mail. We may also send you information about groups and programs. This information may come in a marked envelope with our address on it. We will not use or disclose your child's health information without your written authorization.
Confidentiality – No information regarding other patients may be shared outside the walls of ABC Pediatric Therapy without parental permission.

Patient's Rights

- You have the right to view your child's health record and request a copy of it. There may be a copying and postage fee. You may be asked to show proof of guardianship or parent (driver's license, court order)
- You may request an amendment to your child's record. We are not required to make this change, but it will be noted in the record.
- You may restrict anything in our privacy act. We are not required to honor your request, but will make all efforts to accommodate reasonable requests. You may fax or mail this to us.
- Provide written authorization for uses and disclosures not otherwise permitted by law.

If you believe your privacy rights have been violated, you can file a complaint with our privacy officer or with the Secretary of Health and Human Services. Secretary-US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Parent/Guardian Signature _____

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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: _____ _____

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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? ☐Yes / ☐ No

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

Patient Name _____

ABC Pediatric Therapy Network

ABC parent/guardian:

ABC would like to use your email address to send you tips for making your therapy experience better. For example, remind you when it is time to count your therapy visits to be sure we stay within your insurance contract. Update you on a new funding source that might help you finance therapy. Educate you on using your company pretax plan and when you should sign up to fund therapy pretax.

Please sign below to indicate your wishes in being a part of these updates.

Thank you for trusting ABC with your child's care!

__☐_YES! I would like this email address _____

to be used for keeping me informed.

__☐__No Thank you!

My child's name:_____ DOB:_____ _____

Parent/Guardian signature:_____Date:_____