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 _____

By typing your name above you agree that your typed signature can be used as your actual 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, 2019 through December 31, 2019.

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 _____

By typing your name above you agree that your typed signature can be used as your actual 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: _____

By typing your name above you agree that your typed signature can be used as your actual 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
200Independence Avenue SW
Washington, DC 20201

Parent/Guardian Signature _____ Date:_____

By typing your name above you agree that your typed signature can be used as your actual signature.

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:_____

By typing your name above you agree that your typed signature can be used as your actual signature.

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.
- We recommend that you be involved in your child's treatment session.
  15 minutes prior to the session being complete to enable the therapist to discuss your child's progress

Cancellations:

- If you must cancel an appointment due to an illness or emergency, contact our front 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. If the appointment is not rescheduled within a rolling week then that missed appointment will count as a cancel.
- When an appointment is rescheduled it is expected that your child will attend that appointment. Multiple cancels and reschedules require reviewing the child's schedule and determining if another time may be more beneficial.
- Please verify with the front desk any appointments that will be canceled due to a vacation. We request to receive this information at least 14 days prior to the date which will be missed. We are unable to hold any time slot more than 2 consecutive weeks due to a vacation.
- In the event of inclement weather that may be a safety concern, contact our office if you are unable to make it to the appointment. A fee will not be assessed and a reschedule will be offered.
- Frequently canceled appointments (more than 2 canceled appointments per discipline for every 8 scheduled) will be basis for removal of your reoccurring appointment schedule. You will then be encouraged to schedule with more flexibility, scheduling on a week to week basis after each attended appointment.

No Shows:

Failure to cancel or to appear during an appointment is considered as a no show. A $25 fee will be assessed. Please contact our office immediately to discuss future appointments. If we are unable to reach you within 1 business day after a no show appointment, your child will lose their weekly appointment and will be moved to week to week scheduling. Your child's appointment time will be automatically offered to another child waiting for services.

A Note from the Therapists:

It is expected that families make every effort possible to attend scheduled appointments. When therapists establish a plan of care for your child, they base the goals and progress shared with the insurance company on the child having consistent therapy sessions (weekly). If your child misses appointments or arrives late, they will not meet their goals as quickly, and your child will likely need to be enrolled in therapy for a longer period of time. The success of treatment sessions depends on consistency and timeliness. In the event that a family does have to cancel, it is strongly encouraged that it be rescheduled, even if it is with another therapist. ABC therapists appreciate it when another therapist provides care for one of their reoccurring patients. It gives the therapist new ideas and a different perspective to include in your child's treatment plan. ABC therapists are always in close communication with each other. Any other concerns regarding your child , please discuss this with your therapist.

Signature: _____ Date: _____

By typing your name above you agree that your typed signature can be used as your actual signature.

Why do you have a policy?

We know based on research and data that kids make the best and most significant progress when seen frequently and consistently. Our goal is to partner with you and your child in meeting the goals that have been set as quickly as possible.

Why is it so important that we arrive on time?

Your therapist has scheduled time and activities specific to your child and wants to be able to address each goal thoroughly every session that your child attends. Also each therapist sees a number of patients daily with many appointments being scheduled one after another. So when a child arrives late the time cannot be made up or would interrupt the next child's individual session.

Why do you ask us to reschedule our appointments when we cancel?

We want to provide the best outcomes possible for each child seen at ABC. This requires consistent attendance and timely arrival at least weekly. Any cancellations interrupt the progress of therapy and can make the time in therapy longer and reduce the quality we are providing.

What if my therapist is not available to reschedule with?

We have staffed ABC to allow rescheduling to occur. Our friendly front desk staff will do everything they can to find a time that works. Our therapists are hand selected and have all completed strict competencies in their area of expertise.

What if I do cancel more than 2 of 8 scheduled appointments?

By the 2nd cancel the policy should have been reviewed with you by your therapist and/or front desk person at least 2X since you began your initial treatment at ABC. The cancel history information we gather encourages ABC to offer other options for getting your child's needs met. Our primary goal is to meet your child's needs and successfully discharge them from therapy as quickly as possible.

What options do I have once I have been removed from my weekly time?

Once it has been determined that setting weekly reoccurring appointments is not providing your child a chance at success with his or her goals you will be offered a "flexible scheduling" status.

What does “flexible scheduling” mean?

It can often be hard for some families to schedule and keep weekly reoccurring appointments. We realize that families have a lot going on. “Flexible scheduling” provides families the flexibility they may need. It allows the family to tell ABC what time works for them each week. This may change as often as the family needs it to and is scheduled by the parent one week prior to the next appointment. These appointments can be made by phone or at the check -out desk following each appointment.

In order to provide the most flexibility to you and your family scheduling with the therapist available that matches your time request is preferred. Even with a policy in place all therapists do get cancels. So sometimes you may get lucky and be able to coordinate with a particular one but this does not meet ABC’s goal of getting your child in consistently. We want your child to meet his or her goals.

If you find a time that works for you, attend it consistently with timely arrival for at least 4 weeks, and it becomes available on a therapist schedule you can discuss being placed back into a weekly reoccurring appointment.

ABC’s goal is to create the best life for as many children as we can. We know that it requires commitment and dedication from the family to do this. We also understand that families have things come up and commitments that they need to attend. Our staff does everything they can to provide flexible options for families. However, ABC is a business and each staff member only has so much available time to give. It is important that the time ABC gives is spent providing successes for families. This requires consistent weekly attendance. ABC wants to makes sure that each and every time slot available is full each week so that we can impact as many children as possible. When a family cancels an appointment this can be a missed opportunity for another family who may be waiting for an available time to have their child’s goals met.

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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? Yes No

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: _____

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:_____

By typing your name above you agree that your typed signature can be used as your actual signature.

Patient Name _____