PEDIATRIC THERAPY ASSOCIATES

Providers of Occupational, Physical, and Speech-Language Therapy

"Making a difference each step of the way!"

OFFICES OF HANDS-ON THERAPY, INC. ~ PRYOR PHYSICAL THERAPY, INC. ~ SPEECH SOLUTIONS, INC.

2501 East Moore Avenue, 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: (mm,dd,yy)_____ SSN#:_____

Referred by:_____

Primary Care Physican:_____

Mother's Name:_____ Age: _____

Address:_____City_____

Occupation: _____ Phone _____

Mother's Employer: _____DOB:_____SS#_____

Father's Name: _____ Age: _____

Address:_____City_____

Occupation: _____ Phone _____

Father's Employer:_____DOB:_____SS#_____

Email address_____

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

_____ _____

_____ _____

_____ _____

Emergency Contact (not living in same household)

Name: _____ Phone:_____

Address:_____

Relationship:_____

Patient's Private Insurance Information

Name of Insurance Company_____

Insured's Name_____ Insured's DOB_____

Policy or ID# _____ Group #_____

Address _____

Phone #:_____ Effective Date:_____

Employer's Address _____

Secondary Insurance

Name of Insurance Company_____
Insured's Name_____ Insured's DOB_____
Policy or ID# _____ Group #_____
Address _____
Phone #:_____ Effective Date:_____
Employer's Address _____

Medicaid

Medicaid Number_____
Full Name Listed on Medicaid_____

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/No

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 _____

I certify that I have provided accurate information and answered all questions on this form truthfully to the best of my knowledge. 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 that the insurance carrier may pay less than the actual charges billed for services. I agree to be responsible for payment of all services rendered to my child.

_____ _____

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 2501 East Moore Avenue, 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.

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/GUARDIAN DATE

SIGNATURE OF PATIENT/GUARDIAN DATE