Pediatrics Plus, Inc.

specialized services for children with special needs

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301 West 26th Street Lynn Haven, FL 32444
Phone: (850) 769-5371 Fax: (850) 872-9558

Date: _____

Child's Name: _____ **Date of Birth**: _____

Address (where child resides): _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Mother's Name: _____ Work Phone: _____

Cell Phone: _____ Permission to receive reminder texts? Yes No

Father's Name: _____ Work Phone: _____

Cell Phone: _____ Permission to receive reminder texts: Yes No

Email address: _____ Permission to receive reminder emails: Yes No

Mailing address (if different from above): _____

City: _____ State: _____ Zip: _____

Child lives with: Both Parents Mother Father Foster Parents: _____

Grandparents:_____ Guardians: _____

Name/Ages of Siblings in home: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number(s): _____

Primary Care Physician: _____ **Referring Physician:** _____

Primary Insurance Company and Phone # _____

Insurance ID #: _____ Group #: _____

Guarantor/Name of Insured: _____ Relationship to Patient: _____

SSN: _____ DOB: _____ Employer Name: _____

Secondary Insurance Company and Phone #: _____

Insurance ID #: _____ Group #: _____

Guarantor/Name of Insured: _____ Relationship to Patient: _____

SSN: _____ DOB: _____ Employer Name: _____

Interested Services: ☐Occupational Therapy ☐Physical Therapy ☐Speech Language Therapy ☐Feeding Therapy ☐Tutoring Services ☐Diagnostic Testing for: _____ ☐Other: _____

Reason for seeking services: _____

I would like therapy to help my child with: _____

Precautions/Contraindications/other things we should know: _____

_____

Medication	**Dosage**	**Reason for taking**

Allergies: _____

☐ Official testing completed. Approximate age: _____

Hospitalizations (reason/approximate age):

_____

Surgeries/Medical Tests: _____

_____

Does your child attend: ☐ Daycare ☐ Preschool ☐ Play Group

If yes, location and frequency: _____

If school age, name of current school: _____

Does your child have an IEP or 504 plan? ☐ Yes ☐ No

Does your child receive other services: ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy

If yes, Provider Name(s) and Clinic(s): _____

_____

List any other professionals, schools and/or agencies who are currently seeing (or have seen) your child:

CMS Case worker: _____ Neurologist: _____

CHS Early Steps: _____ Orthopedist: _____

Ear, Nose, Throat: _____ Audiologist: _____

Mental Health/Behavioral Specialist: _____

Other Specialist Physician: _____

Pregnancy/Delivery History:

Child was born: __ full term __ pre-term Gestational age: _____ Birth weight: _____ Length: _____

Yes	No	
☐	☐	Child required NICU stay. If yes, duration of NICU stay: _____
☐	☐	Child required oxygen and/or ventilator support. If yes, describe: _____
☐	☐	Child had other delivery/post-delivery complications. If yes, describe: _____

_____

Sensory Profile: My child ...

☐	☐	dislikes getting hands or face dirty and/or exploring new surfaces with hands
☐	☐	dislikes getting hair cut and/or nails trimmed
☐	☐	dislikes getting dressed/undressed and/or is bothered by types of clothing/tags in clothing
☐	☐	dislikes getting teeth brushed and/or hair combed
☐	☐	appears oblivious to danger
☐	☐	is a picky eater. If yes, describe likes and dislikes: _____

_____

☐	☐	avoids certain temperatures of food. If yes, describe: _____
☐	☐	has trouble chewing certain foods and/or gags often when eating
☐	☐	is sensitive to certain sounds and/or startles easily to sound. If yes, describe: _____

_____

☐	☐	avoids certain movements/appears fearful of movement
☐	☐	seeks excessive movements (such as spinning). If yes, describe: _____
☐	☐	displays self-injurious behaviors (such as biting, head banging)

Does child wear glasses? ☐Yes ☐No If yes, what is the correction for? _____

Do you have concerns with child's vision? ☐Yes ☐No

Has child's hearing been tested? ☐Yes ☐No If yes, results: _____

Do you have concerns with child's hearing? ☐Yes ☐No

Does child have a history of ear infections? ☐Yes ☐No If yes, how many? ____

PE tubes: ☐Yes ☐No If yes, date: _____

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Patient Authorization Form

Parents: Please read and initial each line. Please sign and date at the bottom.

_____ **Consent to treat:** I am aware of my child's diagnosis/reason for referral and wish to receive treatment at Pediatrics Plus, Inc. for Pediatric Therapy. I permit its employees and all other persons caring for my child to treat in ways they judge are beneficial to my child. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

_____ **Release of Information:** I give permission to Pediatrics Plus, Inc. and affiliates to release information, verbal and written, contained in my child's medical record, and other related information, to my insurance company, rehab nurse, case manager, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my child's treatment or payment for services provided.

_____ **Notice of Privacy Practices (HIPAA consent):** I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Pediatrics Plus, Inc. In addition, I hereby consent to the use and disclosure of my child's health information for the purposes of treatment, payment and healthcare operations.

_____ **Payment Guarantee:** I agree to pay Pediatrics Plus, Inc. for the services provided to my child. Should my insurance company send payment directly to me, I will endorse said check over to Pediatrics Plus, Inc. Copayments and deductibles are due in full prior to therapy on each date of service. If any law, such as insurance contract, prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. If claim is denied, Pediatrics Plus, Inc, as a courtesy, will file a one time appeal. At that time, pursuit of insurance payment becomes guarantor's responsibility as well as payment for services provided by Pediatrics Plus, Inc.

The Benefit Verification for services is only an explanation of coverage as quoted by my insurance company, and it is not a guarantee of coverage or payment. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment and services.

_____ Notification of Changes: I will notify Pediatrics Plus, Inc, **in advance**, of any changes in my insurance coverage so that coverage and need for prior authorization can be determined. I will provide updated insurance information/insurance cards when any changes occur. I understand that my child may not be able to be seen if changes to my insurance do occur and information is not provided in advance.

I understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my child's treatments unless agreed to in writing by myself and the management of Pediatrics Plus, Inc.

By signing below, I acknowledge that I have read, understand and agree with the above.

Patient's Name: _____ **Parent/Guardian Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

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Cancellation/No Show/Tardiness Policy

Thank you for choosing Pediatrics Plus, Inc. for your child's therapy care. The policies written below are designed to improve our ability to see all of our patients and to provide complete and consistent treatment for your child. We hope that these policies will improve our overall service to all our patients. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your appointments:

1. Therapists often are not able to wait more than 15 minutes for a late appointment**. Please notify your therapist or the front office as soon as you know you will be late.** Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, the session will end typically at the regularly scheduled time.
2. If you need to cancel your child's appointment, our clinic requires that you cancel **24 hours in advance;** special circumstance such as emergency or illness situations will be taken into account.
3. If you have **three consecutive cancellations** of your child's appointments or you miss **more than ½ of your scheduled appointments,** you **may lose your standing appointment** time slot and your child **may be placed on hold** for therapy. You and your child's primary care physician will be notified of such circumstances.
4. If your child does not attend their scheduled appointment without notification of cancellation, you will be considered a "No Show". If you have **two No Shows** for scheduled appointments, your child **will be discharged from all current therapy services,** and you and your child's primary care physician will be notified.
5. If your regular therapist is unavailable to treat your child, we will make every attempt to have your child seen by another skilled therapist. Your lead therapist will share critical information with the substitute therapist to assist with a successful session. Please also note that the lead therapist for your child may change based on the needs of your child and/or therapist.

Please feel free to speak with your therapist about any concerns with these policies or about concerns with your regularly scheduled appointment time. We will do everything possible to provide you with a time that promotes consistency for both you and your therapist.

Wellness Policy

The health and wellness of your child and our staff is very important to us. The following precautions are taken for the health and safety of your child, other children, and the staff at Pediatrics Plus, Inc. Your child should not attend therapy until the following symptoms are gone **for at least 24 hours**:

- Fever (100 degrees or higher)
- Any contagious illness or communicable disease
- Vomiting or diarrhea (3 times in 24 hour period)
- Severe sore throat or strep throat
- Severe/continual cough
- Nasal discharge that is not clear
- Unknown or contagious rash
- Pink Eye or Lice

We will resume therapy earlier if an accompanied doctor's note releases your child back to therapy and indicates your child is no longer contagious. If your child becomes ill while in therapy, he/she will need to be taken home. If your child is exposed to a contagious illness, please inform the staff as soon as possible so we will be able to alert families and staff that may have also been exposed. We will post a notice informing other parents of the contagious disease and keep your child's identity anonymous.

By signing below, I acknowledge that I have read, understand and agree with the above policies.

Patient's Name: _____ **Parent/Guardian Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ *I have reviewed these policies verbally with caregiver.*

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Photo Release Form

I, _____ (Parent's Name)

_____ DO

_____ DO NOT

grant permission to Pediatrics Plus, Inc and it's non-profit, Special Programs for Special Kids, Inc or employees to use photographs and/or video of me and/or my child for use in promotional and educational materials such as brochures, websites, home exercise programs, and advertisements. In giving my consent, I hereby release and hold harmless Pediatrics Plus, Inc and its employees, agents and designees from any and all responsibility or liability. I understand that I will receive no compensation should any images of my child be used.

Patient's Name: _____ **Patient's DOB:** _____

Parent/Guardian Signature: _____**Date:** _____

Print Name: _____

Pediatrics Plus, Inc.

CONSENT FOR EXCHANGE OF PERSONAL AND HEALTH INFORMATION

PARENT/CAREGIVER INFORMATION:

Last Name	First Name	Middle Name	Relationship to child

CHILD'S INFORMATION:

Last Name	First Name/Middle Initial	Date of Birth
Address	City, State, Zip Code	Phone Number

THE PERSON OR AGENCY BELOW MAY EXCHANGE MY CHILD'S INFORMATION:	INFORMATION EXCHANGED MAY INCLUDE:
Pediatrics Plus, Inc. **301 West 26th Street** **Lynn Haven, FL: 32444** **Phone: 850-769-5371** **Fax: 850-872-9558**	**___ All information Relevant to Consultation** **OR** **___Billing and Payment Records** **___Medical, Health, or Developmental Information** **___Psychological, Behavioral, Educational Information** **___Evaluation, Progress Notes, Diagnostic Records, Treatment**

INFORMATION MAY BE <u>EXCHANGED</u> WITH THE FOLLOWING PERSON(S) OR AGENCY(IES):

Agency Name: _____ **Contact: _____** **Address: _____** **City, State, Zip: _____** **Telephone: _____** **Fax: _____**	**Agency Name: _____** **Contact: _____** **Address: _____** **City, State, Zip: _____** **Telephone: _____** **Fax: _____**

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form, although disallowing collaboration between involved parties may limit the quality of services my child receives from any of the agencies. **LENGTH OF TIME:** This consent will be valid from the date that I sign this form until _____ (date). If no date is entered, the form will be valid until <u>the date that I terminate services</u> with Pediatrics Plus, Inc.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

SHARING OF INFORMATION: I know that my child's information may be shared more than one by the person and/or agency(ies) listed above. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). It may still be protected by other State and Federal Laws. Pediatrics Plus, Inc. is not responsible for further release of information by other agencies.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one.

Parent/Guardian Signature: _____Date: _____

Print Name: _____

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Notice of Privacy Practices

This Notice describes how medical information about your child may be used and disclosed and how you can get access to this information. This Notice describes the privacy practices of Pediatrics Plus, Inc.

Patient Health Information : Under federal law, your patient health information is protected and confidential. Patient health information includes information about your child's symptoms, test results, diagnosis, treatment, and related medical information. Your child's health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information: We use health information about you for treatment, to obtain payment, for administrative purpose, for evaluation of the quality of care and so forth. Under some circumstances, we may be required to use or disclose information even without your consent.

Treatment: We will use and disclose your health information to provide your child with medical treatment or services. We may also disclose the information to other health care providers who are participating in your child's treatment and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Administrative: We may ask you to complete a sign-in sheet or staff members may ask you the reason of your visit so we can better care for your child. Despite safeguards, it is always possible in a healthcare provider's office that you may learn information regarding other patients or they may inadvertently learn something about your child. In all such cases, we expect our patients to maintain strict confidentiality.

We may use and disclose your health information to preform various routine functions (e.g. quality evaluations or records analysis). We may use your information to contact you. We may also contact you to provide information about referrals, for follow-up, to inquire about your child's health, or for other reasons.

Special Situations: We may use or disclose identifiable health information about your child for other reasons, even without your permission.

Legal: We may be required by law to report suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities. We may be required to disclose information in response to a subpoena or court order, or as required by law enforcement officials. We may disclose information to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in cases of death. In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about your child. If you sign an authorization, you can later revoke that authorization.

Notice of Privacy Practices (Continued)

Individual Rights: You have certain rights with regard to your health information, for example: You may request restrictions on certain uses and disclosures of your health information, though we are not required to agree to such restrictions. You may ask us to communicate with you confidentially by, for example, sending notices to a special address.
In most cases, you have the right to get a copy of your health information. There will be a charge for the copies. If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information.

You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or administration. There may be a charge for this information.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding health information, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our practices, we will change our Notice and post the new Notice in the admissions area. You can also request a copy of our Notice at any time. If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Pediatrics Plus, Inc.
Attn: Paula Nelson PT, C/NDT
301 West 26th Street
Lynn Haven, FL: 32444
850-769-5371

Patient Acknowledgment
1. I understand that a patient's health information is private and confidential. I understand that Pediatrics Plus, Inc. has procedures to protect a patient's privacy and preserve the confidentiality of every patient's personal health information. I will assist Pediatrics Plus, Inc. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

2. This patient acknowledgment will become part of my permanent record. I further acknowledge that should I become aware of another patient's private health matters, I will not disclose them to others, and I will treat any such knowledge as strictly confidential and private.

3. My signature and initials on the **Patient Authorization** sheet verifies that I understand how Pediatrics Plus, Inc. may use my patient information, that I have read the "Notice of Privacy Practices, " and I agree to be seen and treated under the stipulations as described. You have the right to obtain a paper copy of this Notice upon request.