1725 HERMITAGE BLVD., TALLAHASSEE, FL 32308

PATIENT HEALTH QUESTIONNAIRE

TODAY'S DATE: _____

PATIENT CONTACT INFORMATION

CHILD'S NAME: _____ GENDER: _____

DOB: _____ AGE: _____

PARENT(S)/GUARDIAN(S) NAME:

_____

ADDRESS:

_____

_____

_____

CONTACT INFORMATION:

HOME (_____)_____ **WORK** (_____)_____

CELL #1 (_____)_____ **CELL #2** (_____)_____

EMAIL _____

PLEASE LIST ALL INSURANCE POLICIES THAT YOUR CHILD IS COVERED UNDER:

INSURANCE COMPANY	POLICY NUMBER
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE LIST AN ALTERNATE EMERGENCY CONTACT:

_____

ALTERNATE CONTACT PHONE NUMBER:
(___)_____

WHAT SHOULD WE DO IN THE EVENT OF AN EMERGENCY?:_____

CHILD'S PRIMARY CARE PHYSICIAN:
_____

HOSPITAL PREFERENCE:
_____

ALLERGIES (EX. FOOD, DRUG, LATEX):
_____

Please indicate how any food allergies/sensitivities are handled in your home (example: anaphylaxis - total avoidance: ok as an ingredient or in limited amounts; child able to set limits related to allergy; etc).
_____
_____

Does your child have any other medical conditions that require dietary modification?
_____ Yes (see below) _____ No
If Yes, please further explain: _____
_____

Has your child ever experienced itching, hives, swelling or symptoms like a runny nose wheezing, eye irritation or difficulty breathing after contact with a food, latex or medication?
Yes/No _____

DOES YOUR CHILD HAVE ANY MEDICAL PRECAUTIONS / CONCERNS (EX. SEIZURES, EXTREME ALLERGY REQUIRING IMMEDIATE INTERVENTION)?
Please explain if yes:
_____
_____

PATIENT'S MEDICAL HISTORY

CHILD'S DIAGNOSIS/DIAGNOSES:
_____
_____
_____

OTHER SPECIALISTS / PHYSICIANS / THERAPISTS:
_____
_____
_____

DAYCARE OR SCHOOL YOUR CHILD IS ATTENDING:_____
GRADE LEVEL: _____

PREGNANCY / BIRTH HISTORY: (ANY COMPLICATIONS BEFORE BIRTH?)
_____
_____
_____

AT HOW MANY MONTHS GESTATION WAS YOUR CHILD BORN?
_____

WERE THERE ANY COMPLICATIONS AFTER BIRTH?:
_____
_____
_____

PAST MEDICAL HISTORY / SURGERIES / HOSPITALIZATIONS:
_____
_____
_____

MEDICATIONS & REASONS:
_____
_____
_____
_____

RECENT HEARING & VISION SCREEN (Include dates and results)
_____

DESCRIBE CHILD'S DIET/ EATING HABITS/ FLUID INTAKE/ DIET MODIFICATIONS IF APPLICABLE:
_____
_____

DEVELOPMENTAL MILESTONES (walking, crawling, sitting up, babbling, first words)
_____
_____
_____

WHAT ARE YOUR PRIMARY CONCERNS?
_____
_____
_____

OCCUPATIONAL THERAPY SECTION

FINE MOTOR CONCERNS: _____

DEVELOPMENTAL CONCERNS: _____

SENSORY CONCERNS: PLEASE CHECK ALL THAT APPLY

- ☐ Dislikes clothing tags/ seams
- ☐ Dislikes being held or touched
- ☐ Becomes anxious when feet leave the ground
- ☐ Withdraws from bright/flashing lights
- ☐ Holds hands over ears to protect from sounds
- ☐ Doesn't like teeth brushing
- ☐ Avoids getting messy
- ☐ Dislikes swings/playground equipment
- ☐ Avoids eye contact
- ☐ Dislikes noisy environments
- ☐ Limited food choices
- ☐ Resists certain textures: (please describe)_____

PHYSICAL THERAPY SECTION

LIST OF MEDICAL EQUIPMENT THAT YOUR CHILD IS USING (Braces, walker, crutches, wheelchair):

_____

_____

CHILD'S ABILITIES (rolling, sitting, crawling, and walking):

_____

_____

SPEECH-LANGUAGE THERAPY SECTION

EAR INFECTIONS / HISTORY OF TUBES (how old and how many?):

_____

_____

_____

FEEDING AND/OR SWALLOWING CONCERNS: (EX: chewing difficulties, choking, coughing while eating, excessive drooling)

_____

FAMILY HISTORY OF SPEECH-LANGUAGE THERAPY:

_____

_____

PRIMARY CONCERN (EX. pronunciation of sounds, following directions, social interaction):

_____

_____

_____

HOW DOES YOUR CHILD COMMUNICATE? HOW DO YOU COMMUNICATE WITH YOUR CHILD?

_____

_____

_____

APPOINTMENT PROCEDURES CONTRACT

The purpose of these procedures is to safeguard our therapists from losing valuable time that could be spent treating clients and to accommodate our clients that are on a waiting list. If a family is inconsistent with their appointments, we need to provide other clients the opportunity to be scheduled.

Please call ahead to cancel your child's appointment at least 24 hours in advance. We understand it's not always possible, especially when your child is ill, but we request that you contact the front office regardless.

You must arrive for your child's appointment on time. We recommend that you arrive at least 10 minutes early to check in.

If a child is brought for an appointment more than 7 minutes late without notification, the appointment will be cancelled. It is possible that if your child is late for their appointment 3 or more times in a 3-month period, his or her permanent appointment will be forfeited. An option will be provided to place the child on the call-in list.

For those patients that cancel without at least 24-hour notice or simply do not show for their appointment three times in a 3-month period, the child will be taken off the permanent schedule and will be offered the option to be on the call-in list.

You must arrive 15 minutes prior to the end of your child's session. If you are late picking up your child, you will be asked to stay for the entire appointment time for future appointments. This will ensure that the treating therapist has time to review your child's appointment with you.

Only one parent/guardian can participate during the session unless approved by the therapist. Siblings are not permitted in the treatment area, without prior approval from the treating therapist.

If a child has a permanent treatment time and is removed from the schedule due to insurance or health related issues for 30 days or more, the child's treatment time will be forfeited unless approved by management.

I have read and understand the importance of this Patient/Clinic contract. I will abide by the rules and limitations stated above.

_____

Child's Name Date

_____

Parent/Guardian Signature Date

DISCLOSURE OF INFORMATION

This form should be completed if the parent/guardian would like Progressive Pediatric Therapy Services to release client information and/or documentation to another facility/institution.

RECEIVING INFORMATION:
AGENCY: _____PHONE: _____

ADDRESS: _____FAX: _____

Contact Person: _____

DISCLOSING INFORMATION:
AGENCY: _____PHONE: _____

ADDRESS: _____FAX: _____

Contact Person: _____

Patient Name: _____DOB: _____

Records Requested
_____Medical (Diagnosis, Treatment, Prognosis)
_____Audiometric Assessment/Recommendations
_____Physical Therapy Reports
_____Occupational Therapy Reports
_____Speech-Language Assessment Reports/Data
_____Speech-Language Treatment Plans
_____Speech-Language Progress Reports/Data
_____Psychological Assessment Reports
_____Academic Test Scores/Reports/IEPs
_____Other: _____

I authorize the release of the requested information. I understand this is voluntary.
I understand that if the organization authorized to receive or to disclose the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

I understand that my healthcare and payment of my healthcare will not be affected by my signing this form. I understand I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. I understand this authorization expires in 1 year from the date of this form, I understand I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before they received the revocation.

_____ _____ ____/___/___

Parent or Guardian Signature Relationship Date

CONSENT FOR PARTICIPATION/INFORMED CONSENT WAIVER

Progressive Pediatric Therapy Services provides a specialized intensive exercise program for children with developmental, neurological, sensory, mental, orthopedic, and other types of disabilities. As one might expect, there is some element of risk involved with therapy and rehabilitation including the use of all exercise equipment. Although the risk is greatly reduced with the use of safety equipment and proper supervision, there still remains the risk of injury during participation in the center's activities.

Therefore it is necessary to get your permission to allow: _____
(Print child's name)
to participate in the therapy and rehabilitation provided by the Progressive Pediatric Therapy Services.

I, _____ (Parent/Guardian) hereby release the Progressive Pediatric Therapy from any liability, claims, demands, & causes of action, now or in the future, resulting from soreness or injury however caused, occurring during or after my child's participation in the exercise program.

In signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statements & understand the inherent risks involved with participation in the Progressive Pediatric Therapy Center's exercise program and give permission for my child to participate.

_____ _____
Parent or Guardian Signature Date

Print Parent or Guardian Name: _____

Photo Release

Progressive Pediatric will make every attempt to **not** include your child in individual or group pictures without written consent. We routinely use such photos or videos to promote Progressive Pediatric Therapy, Child Care, The Learning Center, Summer Camp, and other programs or activities using marketing materials or social media.

Photo Release:

I, _____(parent's name) give Progressive Pediatric permission to use my child's _____ (child's name) photograph/video for the purposes of recruitment, advertising, public relations, obtaining grants, or other purposes related to the mission and work of Progressive Pediatric, as well as for the historical records of the organization.

Parent or Guardian Signature _____ Date _____

Observation Permission

Progressive Pediatric will make every attempt to **not** include your child in individual or group observation without written consent. We routinely have student observers or camp tours.

Observation Release: I, _____ (parent's name) give the Progressive Pediatric permission to allow my child _____ to be observed at Progressive Pediatric for the purposes of therapy, teaching, or parent touring of the facilities for the purpose of enrolling their child.

Parent or Guardian Signature _____ Date _____

HIPAA Procedures Form
Health Insurance Portability and Accountability Act

The purpose of these procedures is to safeguard confidential information and to minimize the risk of unauthorized access, use or disclosure of patient information.

Confidentiality is extremely important

- Any documents containing protected health information and personal information will be safeguarded and kept confidential.
- Any phone conversations held with a patient will be held in a private area.
- Questions and discussions regarding therapy and scheduling will be communicated in confidence with the child's parent/caregiver.
- Photos, videoing and livestreaming is not permitted unless permission is granted from the treating therapists and no other patient's or families are included.
- Posting photos, videos or livestreaming material to social media is not permitted without consent from the treating therapist.

I have read, understand and will adhere to the policies stated above. Failure to do so may result in removal from all therapies from Progressive Pediatric Therapy Services.

_____

Child's Name

_____

Parent Name Parent Signature Date

Session and Treatment Accountability

Progressive Pediatric Therapy Services will bill the insurance company provided for therapy services. We must receive all active insurance policies for the child to bill insurance properly.

Please be advised that while we do bill insurance, there is no guarantee that insurance will cover your sessions.

In the event that insurance does not cover any remaining costs parents/guardians are responsible for payment for the balance owed.

In the event that that insurance does not cover costs due to the existence of an insurance policy that Progressive Pediatric Therapy Services was not informed by the parents/guardians existed, parents/guardians will be responsible for payment for balances owed.

Please submit all insurance changes in writing.

Please see front office staff for any questions or specific concerns.

I have read and understand the obligation for services rendered.

_____

Parent / Guardian Signature Date