Pediatrics Unlimited

NEW PATIENT INFORMATION

Patient Name:		**Date of Birth:**
Parent/Guardian Email:		
Address:		
Parent/Legal Guardian Names:		
Parent/Guardian Phone Numbers:		

Emergency Contacts:

1. Name _____ **Phone #** _____ **Relation** _____
This person may pick up my child in case of emergency? ☐ Yes ☐ No

2. Name _____ **Phone #** _____ **Relation** _____
This person may pick up my child in case of emergency? ☐ Yes ☐ No

Insurance Information: (Please present insurance card if it has changed.)

Primary Insurance:	**ID#:**	
Name of Subscriber:	SS#:	**Date of Birth:**

Secondary Insurance:	**ID#:**	
Name of Subscriber:	SS#:	**Date of Birth:**

Additional Information:

Does your child currently receive therapy at another facility? ☐ Yes ☐ No

If yes, Name of Facility: _____

Please check all that apply. ☐ OT ☐ PT ☐ ST ☐ Aquatic Therapy
*If applicable, what days does your child receive these other therapies? _____

Doctors Who Provide Care To Child: (Please list name and specialty.)

_____

_____

Child's Current Allergies: _____

Child's Current Medications: _____

Parent/Caregiver Signature: _____ **Date:** _____

355 OAK GROVE RD. SPARTANBURG, SC 29301
PHONE: 864-595-4225 FAX: 864-595-4821
Occupational Therapy • Physical Therapy • Speech Therapy
9D MAPLE TREE CT. GREENVILLE, SC 29615
PHONE: 864-627-0009 FAX: 864-627-0333

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Pediatrics Unlimited
Comprehensive Treatment Plan Agreement

Patient Name: _____

Date of Birth: _____

FINANCIAL POLICY AGREEMENT

I understand I am responsible for contacting my insurance company or primary care physician to verify benefits and for authorization of any visits to Pediatrics Unlimited, Inc. I understand I am responsible for all costs not covered by my Insurance Company. These costs include, but are not limited to: Services provided which are not covered by my policy; balances after insurance payment; or failure to obtain authorization before my appointments. I understand that co-pays are paid at the time service is rendered unless other arrangements are made. Any outstanding payments will be due by the last business day of the month to avoid interruption of services and additional charges. If a payment is not paid by the last business day of the month, a late fee of $25 will be billed to my account. After 3 consecutive late fees, therapy services will be terminated and collective action will be initiated. Account balances that are paid promptly will avoid these charges.

I understand that my insurance will not be filed until the date that I provide a copy of the patient's insurance card/number. Insurance will not be filed retroactively.

I hereby authorize Pediatrics Unlimited to release to any insurance company or liable third parties any records or information regarding the diagnosis, condition or treatment of the patient. I am agreeing to assignment to Pediatrics Unlimited all payments from insurance companies for therapy services rendered.

I have authorized services at Pediatrics Unlimited and understand that I will be billed by the 7th of each month for outstanding balances. The bill must be paid by the last business day of the month. All checks are to be made payable to Pediatrics Unlimited. All service charges for any checks returned for Insufficient Funds is my responsibility.

I understand my benefits information available at the time of my evaluation. I understand my deductible; copay & coinsurance responsibility is available upon request. I understand that this information is not a guarantee of coverage but is only representative of the information available from my insurance company at the time it was researched.

I understand that all fees are non-negotiable.

INITIAL: _____

NO SHOW / NO SMOKING POLICY

I understand that I am required to call a **minimum of 24 hours prior** to scheduled appointments to cancel, otherwise it will be considered a No Show. **Two No Shows in 6 months**, and/or 3 **weeks of cancelled appointments in a row** will result in the loss of my standing therapy. I understand we are required to maintain 70% attendance per quarter and no more than 25% Late Arrivals per Quarter' A late arrival is defined as missing 50% or more of a session.

INITIAL: _____

I understand smoking is not permitted on the premises. Failure to comply will result in loss of therapy appointment(s).

INITIAL: _____

AUTHORIZATION TO PHOTOGRAPH PATIENT

I, _____, ☐ authorize PEDIATRICS UNLIMITED, INC. to photograph/videotape

☐ do not authorize PEDIATRICS UNLIMITED, INC. to photograph/videotape

Patient: _____ Date of Birth: _____

For these expressed purposes:

☐ Treatment and family education ☐ Research ☐ Publicity ☐ Training/professional development ☐ All

The photograph/videotape will not be used for any other purposes than those authorized on this form. For the privacy of others, taking pictures and videos in common areas is prohibited.

SIGNATURE: _____DATE: _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT:_____

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Authorization To Release Health and/or Psychological Information

I, _____, authorize the release/disclosure of the information originated by Pediatrics Unlimited Inc. I understand information may be mailed or faxed or electronically transmitted when necessary. I understand that this authorization may last up to one year but can revoked verbally or in writing by the authorized person.

[ ] I understand that electronic transmission of information includes email, instant messaging and web-based video conferencing. Email is frequently the most efficient way for school and Pediatrics Unlimited staff to communicate between agency providers. The limitation of electronic transmission of information is that we cannot ultimately guarantee their security. Precautions will include initial verification of email addresses and online identities before clinical information is transmitted.

Any specific information **NOT** to be released may be listed here _____

_____

Patient Information:

Name _____ Date of Birth _____

Release information to:

Pediatrician _____ **Other** (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Neurologist _____ **Other** (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Dev. Pediatrician _____ **Other** (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Early Interventionist _____ **Other** (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Other Healthcare Provider _____ **Other** (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Signature _____ Relationship to Patient _____ **Date** _____

Office Personnel _____ Date _____

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Occupational / Physical / Speech Therapy
PEDIATRIC CASE HISTORY

Date:_____

Patient's Name_____ Nickname_____

Date Of Birth_____ ☐ Male ☐ Female

Reason for Referral_____

All information given in this questionnaire is considered strictly confidential.

Parent/Legal Guardian Name_____Age_____Marital Status_____

Relationship to Patient_____

Cell Phone #_____Email Address _____

Highest Level of Education_____Occupation_____

Parent/Legal Guardian Name_____Age_____Marital Status_____

Relationship to Patient_____

Cell Phone #_____Email Address _____

Highest Level of Education_____Occupation_____

Brothers and Sisters

Name	Age	Developmental, Speech, Hearing or Medical Problems

Has your child received any previous OT, PT, or Speech Therapy? ☐ yes ☐ no
Has your child received other evaluations (OT, PT, ST, psychological, educational, neurological…)? ☐ yes ☐ no

If "Yes" to either above:

Type_____Eval Date_____ Professional's Name/Location_____

Type_____Eval Date_____ Professional's Name/Location_____

Type_____Eval Date_____ Professional's Name/Location_____

DEVELOPMENTAL MILESTONES

Provide the **approximate age** at which your child began to do the following activities:

Crawl _____ Sit _____ Stand _____ Walk _____ Dress self _____

Use toilet _____ Finger feed _____ Self-feed with utensils _____

Babble _____ Say first words (e.g., no, mom, doggie) _____

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Combine words (e.g., me go, daddy shoe) _____ Talk in complete sentences _____

Use simple questions (e.g., Where's doggie?) _____ Engage in conversation _____

PRENATAL AND BIRTH HISTORY

Check any of the factors below that apply:

☐ Need for hospitalization or bed rest ☐ Excessive vomiting ☐ Drug use

☐ Alcohol use ☐ Diabetes ☐ Excessive weigh loss

☐ Smoking ☐ Premature rupture of the membranes ☐ Hemorrhaging

☐ Medications ☐ Trauma/injuries ☐ Excessive weight gain

☐ RH incompatibility ☐ Previous miscarriages ☐ High blood pressure

☐ Measles ☐ Polyhydraminos ☐ Breach delivery

☐ Cesarean delivery

Length of Pregnancy _____ Length of Labor _____ Birth Weight _____

Please describe any other difficulties with the pregnancy or birth of your child _____

_____

If premature birth, any complications? (e.g., pulmonary surfactant use, necrotizing enterocolitis, retinopathy of prematurity, intraventricular hemorrhage?) _____

Was the child in the Neonatal ICU? ☐ no ☐ yes: How long? _____

CHILD HEALTH HISTORY

Has your child:

Had a vision test? ☐ yes ☐ no If yes, results & when: _____

Had a hearing test? ☐ yes ☐ no If yes, results & when: _____

Has your child had any of the following? If yes, describe and give approximate dates. Check any illnesses and your age at which it occurred.

☐ Adenoidectomy _____ ☐ Allergies _____ ☐ Asthma _____

☐ Bronchitis _____ ☐ Chicken pox _____ ☐ Chronic colds _____

☐ Ear infections _____ ☐ Headaches _____ ☐ Heart trouble _____

☐ Measles _____ ☐ Meningitis _____ ☐ Pneumonia _____

☐ Reflux _____ ☐ Seizures _____ ☐ Sinus trouble _____

☐ Tonsillectomy _____ ☐ Tubes in ears _____ ☐ Lead exposure _____

☐ Other _____

Diagnoses: _____

Congenital Abnormalities _____

Surgery _____

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Other hospitalizations_____

Casts or braces_____

List any medications your child is currently taking_____

Check all that apply: ☐ glasses ☐ braces ☐splints ☐ hearing aids ☐ augmentative communication device ☐ wheelchair

FAMILY HEALTH HISTORY

Family members with medical/health problems (please list what relation):

☐ Tourette's Syndrome _____ ☐ ADD/ADHD _____ ☐ Autism _____

☐ Learning Disabilities_____ ☐ Turner's Syndrome___ ☐ Fragile X Syndrome _____

☐ Marfan Syndrome _____ ☐ Down Syndrome_____ ☐ Cleft lip/palate_____

☐ Depression _____ ☐ Anxiety _____ ☐ Phobias _____

☐ Bipolar Mood Disorder_____ ☐ Psychosis_____ ☐ Schizophrenia_____

☐ Other _____

SCHOOL (if applicable)

Teacher's Name:_____School_____Grade in School:_____

What subjects does your child have difficulty with?_____

Does your child receive any school services? Check all that apply.

☐ IEP ☐ Special education classroom full day

☐ IFSP ☐ Early Intervention kindergarten classroom

☐ Section 504 Plan ☐ Classroom aide

☐ Career center/vocational rehab ☐ Tutoring

☐ Special education services in the regular education classroom

Has your child ever missed an extended amount of school? ☐ yes ☐ no If yes, when and why? _____

Has your child ever been suspended or expelled? ☐ yes ☐ no If yes, when and why? _____

FAMILY EXPECTATIONS

What, if anything, would you like to change about the way you and your child communicate with one another?_____

_____

What information would you like to know more about?_____

What would you like your child to achieve in the next 6 months? _____

_____

Parent/Legal Guardian Signature_____

Thank you! Your insights will help us to do our best for you!

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PATIENT and FAMILY BILL OF RIGHTS

WELCOME TO PEDIATRICS UNLIMITED

We are pleased you have chosen our clinic to assist your child with their therapy needs. Our staff includes Physical Therapists, Occupational Therapists, and Speech Language Pathologists. Our goal is to provide quality services to your child. You are the expert on your child and our pediatric team members are experts in their specialty. Together we can help your child improve specific skills and help them reach their full potential. You and your child have rights and responsibilities. We want you to understand these rights and responsibilities so you can help us to provide better service to your child. Please read and sign at the bottom of this statement.

RIGHTS:

DIGNITY: You and your child have the right to be treated with dignity regardless of race, sex, or religious preference.

PRIVACY: Your medical records are private. A complete discussion of your privacy rights is included in the "Notice of Privacy Practices".

PARTICIPATION: It is usually in the best interest of the child for family to participate in therapy for either a whole or part of the session. If this is not possible, we may take a few minutes at the end of the therapy session to consult with you on how the treatment session went and what you can work on at home. You will receive personalized reports every 9 months. A progress summary is recorded once per quarter in your child's electronic medical record.

RESPONSIBILTIES:

CANCELLATIONS, NO SHOWS, & LATE ARRIVALS: We understand that many things occur when dealing with children; however, you have the responsibility to keep scheduled appointments. Usually you will have regularly scheduled appointments that are the same from week to week. **Cancellations:** If you need to cancel an appointment, you will be given the opportunity to make up that appointment within one week of the scheduled appointment. **No Shows**: Your visit will be considered a "No Show" if you did not notify us within 24 hours before the session. **Late arrivals**: If you arrive 15 minutes or more late for a half-hour session or 30 minutes or more late for a 1 hour session, you are considered a "Late Arrival." Please be aware that therapists may be unable to extend your therapy session if you have a late arrival.

If you have 3 weeks of Cancellations, 2 No Shows in 6 months, or 2 consecutive Late Arrivals, you will be asked to schedule appointments on a week-to-week basis and/or attend a Consult Session with a member of management. You are required to attend 70% of therapy sessions per quarter with no more than 25% late arrivals. Failure to meet this criteria can result in loss of regular appointment spot.

SUPERVISION: You are responsible for supervision of children you bring to our clinic. We encourage you to remain on the clinic property during your child's therapy session. If you do need to leave, please give your cell number or a number you can be reached at by the office staff. We ask that you arrive 10 minutes early to pick-up your child if you decide to leave.

ILLNESS: Please do not bring your children if they are sick. If they are not feeling well, they will not be ready to learn. Fevers, pink eye, stomach viruses, and other contagious illnesses should be reasons to reschedule your appointment. A child who has been diagnosed with the flu must be fever free for 24 hours before attending a therapy session.

CONCEALABLE WEAPONS: Pediatrics Unlimited Inc prohibits the possession of firearms or other weapons on company property.

CELL PHONES: We would like for your child to receive full benefit from their time here. So, when you are in therapy sessions we ask that you put your cell phone on a silent ring and only answer emergency calls, so that it doesn't distract your child and therapist.

Pediatrics Unlimited is a privately owned practice. If your child needs additional services, we can direct you to those agencies. Pediatrics Unlimited is a teaching facility. If you do not want a student involved in your child's plan of care, please let your treating therapist know.

Signing this page indicates that you understand your rights and responsibilities and give your permission to Pediatrics Unlimited, Inc. to provide therapy services to your child.

SIGNATURE: _____ Date: _____

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PEDIATRICS UNLIMITED

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice please contact:

Alex Maxwell, Privacy Officer

Or

Kathy Maxwell, Security Officer

This Notice of Privacy Practices describes how we may use and disclose protected health information to carry out treatment, payment or health care operations. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health and related health care services.

Pediatrics Unlimited is required to abide by the terms of this Notice of Privacy Practices. We may change our notice at any time. The new notice will be effective for all protected health information. Upon your request, we will provide you with any revised Notice of Privacy Practices by requesting that information in writing. A revised copy will be given to you within 30 days.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

You will be asked by our office to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations. Pediatrics Unlimited will use or disclose your protected health information as described below Your protected health information may be used and disclosed by our therapists, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used to pay your health care bills.

The following are examples of the types of uses and disclosures of your protected health care that our office is permitted to make once you have signed our consent form. These are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once your have provided consent.

1. **Treatment** We will use and disclose your protected health information to provide and coordinate your care and any related service. This includes coordination or management of your care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary to any health agency that provides care to you. We will also disclose protected health information to a physician who is or will be treating you.

2. **Payment** When needed, we will disclose your protected health information to obtain payment for services. This may include disclosures to you health insurer to get approval for a recommended therapy, to determine whether you are eligible for benefits, to determine whether a particular service is covered under your health plan, and when required for utilization review activities.

3. **Health Care Operations** Pediatrics Unlimited may use or disclose your protected health information for management or administration of the clinic. Health Care operations may include: (1) quality control and improvement activities (2) staff review and and training (3) certification, licensing and credentialing activities (4) health care audits by third party payers (5) calling your name during for your regularly scheduled appointment (6) contacting you to remind you of an appointment (6) newsletters about our clinic and the services we offer. We will share your protected health care information with third party "business associates" including billing services for the practice.

As required through your written consent, we will disclose protected health care information to other agencies including but not limited to BabyNet, early intervention programs, and schools.

Other use of disclosures that may be made without written consent We may disclose your protected health information in the following situations without your authorization: (1) When legally required to comply with any Federal, State, or local laws (2) When there is a risk to public health such as (a) to prevent disease or injury (b) notification of a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease (3) To report abuse, neglect, or domestic violence (4) Legal proceedings which are in response to a court order (5) For law enforcement purposes to (a) report physical injuries (b) court ordered warrant, subpoena, or summons (c) need to report a crime in emergency situations

Other uses of disclosures that may be made with an opportunity to object The practice may disclose protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. If you do not object to these disclosures, Pediatrics Unlimited will infer that you do not object, and in its professional judgment that it is in your best interest to disclose information.

Uses and disclosures provided by you Other than the circumstances described above, Pediatrics Unlimited will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time.

Pediatrics Unlimited

II. YOUR RIGHTS

You have the right to inspect and copy your protected health information You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A designated record set is medical and billing records and any other records that the clinic uses to provide services to you.

The clinic may deny your request to inspect or copy protected health information if it is determined that the access requested is likely to endanger the safety of a person, or cause substantial harm to a person referred to in the information. You have the right to request a review of this decision.

You may not inspect or copy certain records by law, including information compiled for civil, criminal or administrative action or proceeding and protected health information that is subject to a law that prohibits access to protected health information.

You must submit a written request to Pediatrics Unlimited. You may be charged a fee for the cost of copying, mailing or other cost incurred to comply with your request.

You have the right to request a restriction of your protected health information You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must be in writing and clearly state the restrictions and to whom you want the restrictions to apply.

You have the right to amend your protected health information During the time the clinic maintains your protected health information, you may request an amendment of your information in a designated record set. Request for amendment must be submitted in writing to Pediatrics Unlimited. Your request must supply a reason to support the requested amendment. The clinic may deny your request in some instances. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with copies of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made You have the right to request an accounting of the clinic's disclosures of your protected health information made for purposes other than treatment, payment or health care operations as described in this notice. It excludes notifications we have made to you, for a directory, to friends and family involved in your care, to individuals or agencies which you authorized by signing a release form and certain other disclosures the practice is permitted to make without your authorization. The request of accounting must be made to our clinic in writing and should state the time period for which you wish the accounting for disclosures to take place. This is not required for disclosures prior to April 14, 2003. The clinic will not charge you for the first request of any 12 month period. Subsequent accountings may require a reasonable fee.

You have the right to a paper copy of this notice.

III. CONTACTS

The clinic's contact person regarding our duties and your rights under the HIPPA regulations is the Privacy Officer. Complaints to the clinic should be directed to the Privacy Officer at the following address:

Alex Maxwell
355 Oak Grove Rd.
Spartanburg, SC 29301
864-595-4225

The Privacy Officer can be contacted by telephone at: 864-595-4225

I, _____, acknowledge that I have read Pediatrics Unlimited, Inc. Notice regarding Privacy of Personal Health Information.

Signature _____ **Date** _____