1725 HERMITAGE BLVD., TALLAHASSEE, FL 32308

PATIENT HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS AS THOROUGHLY AS POSSIBLE SO WE HAVE A BETTER UNDERSTANDING OF YOUR CHILD'S NEEDS.

TODAY'S DATE: ______________________________

PATIENT CONTACT INFORMATION

CHILD'S NAME: ______________________________________ **GENDER:** MALE / FEMALE (circle one)

DOB: ______________________________ **AGE:** __________

PARENT(S)/GUARDIAN(S) NAME:

____

ADDRESS:

____

____

____

CONTACT INFORMATION:

HOME (____)__________________ **WORK** (____)________________________

CELL (____)__________________

EMAIL ____

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):

____

MEDICAL PRECAUTIONS:

____

PATIENT'S MEDICAL HISTORY

CHILD'S DIAGNOSIS/DIAGNOSES:

____
____
____

HEIGHT: ________ **WEIGHT:** ________
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)

____

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

____
____
____

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)

____

PREVIOUS SPEECH – LANGUAGE THERAPY:

____

FAMILY HISTORY OF SPEECH-LANGUAGE THERAPY:

____

____

HOW DOES YOUR CHILD REQUEST DESIRED ITEMS?

____

____

____

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

____

____

____

ALLERGY QUESTIONNAIRE

NAME: ______________________________ DATE: _________________________

1. Does your child have other food allergies/sensitivities? _____ Yes (see below) ___ No
Please indicate how these 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).

____

____

Is your child allergic to certain foods such as fruit or nuts?

____

Does your child have food sensitivities? _______

Has your child ever experienced itching, hives, swelling or symptoms like a runny nose wheezing, eye irritation or difficulty breathing after a:

- Dental exam or procedure
- Contact with a balloon
- An exam by someone wearing gloves

Have you ever been informed by a doctor that you child
Has a latex or rubber gloves allergy? ____________

Does your child have any other medical conditions that require dietary modification?
_____ Yes (see below) _____ No

Does your child have celiac disease or gluten intolerance? How long has your child been diagnosed with celiac disease or gluten intolerance? _________

In your opinion, what is your child's level of compliance with the gluten-free diet?
_____100% _____75% _____50% _____25%

Does your child have difficulty following the gluten-free diet if you are not able to monitor or help him/her?
_____ Yes _____ No

What type of symptoms will your child have if he/she has ingests gluten? Will he/she tell someone he/she is sick? _____ Yes _____ No

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 any physical activity/exercise, intense exercise program, and the use of all exercise equipment (including the Therasuit & the Universal Exercise Unit). Although the risk is greatly reduced with the use of safety equipment, proper supervision, training and skilled trainers, 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 exercise program 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: ____

Address: ____

Phone: ____

Session and Treatment Accountability

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.

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

I have read and understand the obligation for services rendered.

____

Signature   Date

CANCELLATION CONTRACT
Procedures Form

Name Date

Home phone: Work phone: Cell phones:

The purpose of these procedures is to safeguard our therapists from losing valuable time that could be spent treating clients and to accommodate our kids that are on a waiting list. If a family is not being consistent with their appointments, we need to give others the opportunity to be scheduled.

We understand it's not always possible, especially when your child is sick, but please call ahead to cancel your child's appointment at least 24 hours in advance.

For those patients that do not give at least 24 hour notice or simply do not show three times in a 3 month period, your child will forfeit his/her permanent appointment to a new child. You will be put on the call in list.

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

Signature Date

Mandatory Reporter

A **mandated reporter** is a person who, because of his or her profession, is legally required to report any suspicion of child abuse or neglect to the relevant authorities. These laws are in place to prevent children from being abused and to end any possible abuse or neglect at the earliest possible stage.

Behavior analysts, Speech-Language Pathologists, Occupational Therapists, Physical Therapists, Music Therapists, and Teachers act in the best interest of their clients, taking appropriate steps to support clients' rights, maximize benefits, and do no harm. They are also knowledgeable about and comply with applicable laws and regulations related to mandated reporting requirements.

Signature ____ Date ______________

Print Name ____

DISCLOSURE OF INFORMATION

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.

________________________ ________________________ ____/____/____
Signature **Relationship** **Date**

You may refuse to sign this authorization

HIPAA Procedures Form
Health Insurance Portability and Accountability Act.

Name ____________________ Date

Address ____________________ City State

Phone Number ____________________

Cell Phones: ____________________ Email:

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, personal information, and the patients folders will not be left open or unattended in a public area.
- Any phone conversations held with a patient will be held in a private area, behind closed doors.
- No discussion regarding patients and their personal information will be held in open public areas.
- You will only access and use information necessary to complete an authorized task. No patient folders or copies of patient information will leave this office.
- All information or questions of the parent regarding a patient's therapy sessions should be redirected to a staff member.

I have read and understand the importance HIPPA's patient confidentiality. I will abide by the rules and limitations stated above.

Signature ____________________ Date

Photo Release

PPTS will make every attempt to **<u>not</u>** include your child in individual or group pictures without written consent. We routinely use such photos to promote PPTS summer camp, and other activities of PPTS, and request donations for scholarships.

Photo Release: I, ________________________________ give Progressive Pediatric
(Parent's name)

Developmental Center or Progressive Pediatric Therapy Services permission to use my child's photograph for the purposes of recruitment, advertising, public relations, obtaining grants, or other purposes related to the mission and work of PPTS, as well as for the historical records of the organization.

Signature ____ Date ______________

Print Name ____

Observation Permission

PPTS 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, ______________________________ give the Progressive Pediatric
(Parent's name)
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.

Signature ____ Date _____________

Print Name _______________________________________

Signature: ______________________________ Date: ___________________

1725 Hermitage Blvd. Tallahassee, FL 32308 ♦ (850)325-6301 ♦ Fax: (850)325-6302

Patient Bill of Rights

- A patient has the right to respectful care given by competent personnel.
- A patient has the right to every consideration of his privacy concerning his/her own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discreetly.
- A patient has the right to expect that all communication and records pertaining to his/her medical care should be treated as confidential except as otherwise provided by law.
- The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
- The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's next of kin or to another appropriate person.
- A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.
- The patient who does not speak English is permitted to bring an interpreter to his/her therapy sessions.
- The facility shall provide the patient, upon written request, access to all information contained in his/her medical records.
- The patient has the right to expect good management techniques to be implemented within the facility out of consideration for the use of the patient's time and to avoid the personal discomfort of the patient.
- The patient has the right to examine and receive detailed explanations of his bill.

Signature: ______________________________ **Date:** ____________________