NEW PATIENT INTAKE

Today's Date:____________________

Patient Name:____ Gender: ☐ M ☐ F

Date of Birth:__________________________________ Patient SSN:________________________________

Address/City/State/Zip:____

Patient Diagnosis/Chief Complaint:____

Parent/Guardian Name(s):____

Home Phone:_________________________________Mobile Phone:________________________________

Email (to send evaluation to):____

Responsible Party: (parent/guardian responsible for patient's bill)

Name:____ Date of Birth:___________________________

SSN:__________________________________Relationship to child:______________________________

Home Phone:_________________________________ Mobile Phone:________________________________

In Case of Emergency Contact Information:

Name:____

Relationship to child:____

Home Phone:_________________________________ Mobile Phone:________________________________

Name:____

Relationship to child:____

Home Phone:_________________________________ Mobile Phone:________________________________

Primary Care Physician:____

PCP Phone Number:____

PCP Address:____

Insurance Information:

Arkansas Medicaid / PASSE / SoonerCare Number:_______________________________________

Private Insurance Name:____

Claims Address:____

Telephone:____

Policy Number:____

Policy Holder's Name:____

Policy Holder's SSN#:____

Policy Holder's DOB:____

- Please provide copy of AR Medicaid/SoonerCare and/or Private Insurance Card(s)
- Please provide copy of Driver's License

I, ______________________________ am the contact person for all scheduling of this child's therapy times. The therapist shall contact me for any changes in therapy sessions.

I, ______________________________ am responsible for all scheduled treatment sessions. Any scheduling changes or cancellations will be my responsibility. I have read, understand and agree to the terms of the cancellation policy that was given to me.

Please list the name and phone number of any person(s) who will be responsible for dropping off the child or picking up the child from therapy sessions (a copy of each person's driver's license will be required).

Name:______________________________ Phone:______________________________

Name:______________________________ Phone:______________________________

Name:______________________________ Phone:______________________________

Name:______________________________ Phone:______________________________

PHOTO PERMISSION: (Please initial and date)

1. I give permission for photograph/video of my child for the purposes of treatment, education, and documentation. __________ / __________
2. I give permission for photograph/video of my child to be used for advertising, brochure, internet (clinic website, Facebook, etc.) __________ / __________

I hereby give In-Sync Pediatric Therapy Center permission to evaluate and treat my child and understand there will be written, oral and electronic communication between care providers, physicians, insurance companies, and In-Sync Pediatric Therapy staff. I understand that all practices of confidentiality will be followed in use of the information gathered.

______________________________ ______________________________
Signature of Parent/Guardian of Patient Date

How did you hear about us? (Please circle any and all that apply)

Physician Phonebook

Internet Search Friend

Website

Facebook Page

Twitter

Television

Radio

Other:___________________________________

HISTORY INTAKE FORM

(Please complete and return)

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

Patient Name:_____________________________ Gender: ☐ M ☐ F DOB:___________________

Diagnosis:_____________________________________ Primary Phone:______________________

Mother's Name:_________________________________ Work Phone:________________________

Father's Name:_________________________________ Work Phone:________________________

Guardian's Name:_______________________________ Message #:_________________________

Siblings Names and Ages:____

____

Who lives in the home with the patient?____

Who is the patient's primary care giver?____

Has the patient received any previous therapy? ☐ Yes ☐ No

If yes, when:______________________________ How long:________________________________

Where:___________________________________ Date of last evaluation:______________________

Does the patient attend daycare, preschool, or school: ☐ Yes ☐ No

If yes, where:____

What languages are used in the home?____

What is the patient's religious preference?____

HEALTH OF MOTHER DURING PREGNANCY

1. Any illnesses or accidents: ☐ Yes ☐ No If yes, please explain:___________________

   ____

   ____

2. Any medications: ☐ Yes ☐ No If yes, what:_________________________________

   ____

3. Pregnancy:_________months
4. Labor:_____________hours
5. Baby was delivered: ______Cesarean ______Vaginal

6. Baby's birth weight: ______lbs. ______ounces
7. Expected due date:_________________________________
8. Any difficulty at time of birth: ☐ Yes ☐ No If yes, please explain:__________________

____

____

HEALTH OF PATIENT

1. Serious illness or deformities: ☐ Yes ☐ No If yes, please explain:________________________

   ____
2. Serious accidents or injuries: ☐ Yes ☐ No If yes, please explain:__________________

   ____
3. Any surgeries: ☐ Yes ☐ No If yes, please explain:_____________________________________

   ____

   ____
4. History of high fever: ☐ Yes ☐ No If yes, please explain:________________________

   ____
5. History of seizures: ☐ Yes ☐ No If yes, please explain:________________________

   ____
6. History of eye problems: ☐ Yes ☐ No If yes, please explain:__________________

   ____
7. History of ear infections: ☐ Yes ☐ No If yes, how many?____________________

   ____
8. Has the patient had tubes in his/her ears? ☐ Yes ☐ No If yes, when?______________

   ____
9. Allergies: ☐ Yes ☐ No If yes, please explain:_____________________________________

   ____
10. Is the patient taking any medications now: ☐ Yes ☐ No If yes, please explain:____________

    ____

    ____
11. Does the patient have frequent colds, sore throats, or earaches: ☐ Yes ☐ No
12. Has the patient's tonsils and/or adenoids been removed: ☐ Yes ☐ No

    If yes, when?____

FEEDING HISTORY

1. Was the patient bottle fed? ☐ Yes ☐ No Breast fed: ☐ Yes ☐ No
2. Does the patient take a bottle/nurse at this time? ☐ Yes ☐ No
3. Any difficulties latching onto the bottle or breast? ☐ Yes ☐ No

If yes, please explain:____

____

4. Any feeding difficulties (example: spit up, vomiting, signs of reflux): ☐ Yes ☐ No If yes, please explain:____

____

5. Is the patient a picky eater? ☐ Yes ☐ No If yes, approximately how many foods do they eat?____

DEVELOPMENTAL HISTORY OF PATIENT (please circle yes or no and give age)

1. Holds head up: ☐ Yes ☐ No Age:________
2. Rolls over: ☐ Yes ☐ No Age:________
3. Sits alone: ☐ Yes ☐ No Age:________
4. Crawls: ☐ Yes ☐ No Age:________
5. Pulls to stand: ☐ Yes ☐ No Age:________
6. Stands alone: ☐ Yes ☐ No Age:________
7. Walks alone: ☐ Yes ☐ No Age:________
8. Run: ☐ Yes ☐ No Age:________
9. Grasps toys: ☐ Yes ☐ No Age:________
10. Puts things hand-to-hand: ☐ Yes ☐ No Age:________
11. Feeds self with fingers: ☐ Yes ☐ No Age:________
12. Feeds self with spoon: ☐ Yes ☐ No Age:________
13. Scribbles: ☐ Yes ☐ No Age:________

Describe any positions or movements that the patient likes or dislikes:_______________________________

____

Describe any specific concerns you have about the patient or his/her development:__________________

____

____

SPEECH HISTORY

1. Does the patient have a speech impairment: ☐ Yes ☐ No
2. Does the patient have a hearing impairment: ☐ Yes ☐ No
3. Is the patient responsive to sounds or voice: ☐ Yes ☐ No
4. When did the patient begin to use single words: ______months
5. When did the patient begin to use sentences: ______months
6. Does the patient speak in: ______words ______phrases ______complete sentences

7. When were you first concerned about a speech or hearing impairment:______________________

____

8. Can the patient be understood by parent/guardian: ☐ Yes ☐ No
9. Do other family members have a speech or hearing impairment: ☐ Yes ☐ No

   If yes, who?____

10. Has the patient ever had more words than he/she has now? ☐ Yes ☐ No
11. Has the patient's hearing ever been evaluated? ☐ Yes ☐ No

    If yes, when?______________________________________Pass? ☐ Yes ☐ No

Are there any concerns with the following?

Tongue	______	Throat	______	Drooling	______
Jaws	______	Teeth	______	Writing	______
Palate	______	Chewing	______	Reading	______
Nasal Passages	______	Swallowing	______		

Can the patient do the following without help?

Dress/Undress:	☐ Yes	☐ No	Bathe:	☐ Yes	☐ No
Clothes fasteners:	☐ Yes	☐ No	Brush teeth:	☐ Yes	☐ No
Go to bathroom:	☐ Yes	☐ No	Feed self:	☐ Yes	☐ No

OTHER IMPORTANT INFORMATION/CONCERNS

What specific skills or areas are you concerned with regarding school readiness?___________________

____

Does the patient have difficulty adapting to change: ☐ Yes ☐ No If yes, please explain:_______

____

What areas do you consider as strengths for the patient:______________________________________

____

Does the patient need to be reminded or redirected to complete tasks: ☐ Yes ☐ No

If yes, please explain:____

____

Does the patient have daily responsibilities or chores at home: ☐ Yes ☐ No If yes, please explain:_

____

____

How long can the patient stay on task:____

____

Can the patient complete a task in a timely manner: ☐ Yes ☐ No

Are reminders or time limits required: ☐ Yes ☐ No

Can the patient express his/her needs adequately: ☐ Yes ☐ No

If yes, is it done verbally, by pointing, etc:____

____

What types of activities/interests does the patient like:_______________________________

____

Does the patient avoid any activities: ☐ Yes ☐ No If yes, please explain:__________

____

BEHAVIOR (please circle the statements that describe the patient)

Happy	Nervous	Prefers to play alone	Destructive
Temper tantrums	Sensitive	Nightmares	Stubborn
Cries easily	Thumb sucks	Overactive	Easily managed
Slow learner	Shy	Outgoing	Unusual fears
Jealous	Sad	Demands excessive	Affectionate
Friendly	Attention	Has NO playmates	Plays well with others
Energetic	Likes school	Has playmates	Overly talkative

______________________________ ________________ ________________
Signature Relationship to child Date

ADDITIONAL INFORMATION MAY BE ADDED IN THIS SPACE OR ON THE BACK OF THIS FORM.

____

____

____

____

____

____

____

____

____

PERMISSION TO BILL

Insurance Billing

I, ____________________________________, give In-Sync Pediatric Therapy Center, LLC permission to **bill my insurance** for occupational, physical, and/or speech therapy services. I understand that private insurance must be billed before Medicaid benefits can be utilized.

Personal Billing

I acknowledge that if there is a lapse of coverage due to losing Medicaid benefits, or private insurance coverage, In-Sync Pediatric Therapy Center, LLC will **bill me directly** for any dates of service that are not covered by my insurance.

The amount to be billed to the responsible party will be the current Medicaid rates for evaluation and/or therapy treatment.

____ ______________________

Signature Date

CANCELLATION POLICY

Welcome to our office. We appreciate the opportunity to work with you and your family. Our office is dedicated to high quality patient care. To maintain our high standards, we believe that it is important we communicate our policies to you. Please take a moment to read and become familiar with this policy. Should you have any questions, we are happy to help. By presenting this policy in advance, we can avoid any surprises or misunderstandings. We appreciate your time and cooperation.

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your child's therapist. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday appointments, our office appreciates being notified no later than Friday afternoon. This will allow other patients in need of care to be accommodated. It is unfair to both the other patients and therapists to not allow for others to schedule into the open time slots. You may call the clinic at 479-474-6444 or contact your therapist directly by phone or text. Our therapists are always available to you.

- You are expected to be on time for your scheduled appointment and arrive on time to pick up your child. This is to ensure that parents are present so that the therapist can collaborate with the parent/guardian(s) and allows other children's sessions to begin on time.

- Late fees and charges will be implemented if you are consistently late to your appointment time or are late to pick up your child. *Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent/guardian(s).*

- Effective January 1, 2017, In-Sync will be enforcing a $25.00 charge for missed appointments without any contact to explain your absence. Three consecutive no-shows require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time slot and be placed on a waiting list.

- We require an 80% attendance rate and will need to take the patient off the therapist's schedule if it is not adhered to. Late attendance will also affect this rate. *Note: We will be tracking visit numbers and as a courtesy, we will notify you when your percentage drops below the required 80%.*

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to three weeks. We will then have to place you on a waiting list and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

Parent or Legal Guardian Signature	Date

Acknowledgment of Receipt of Privacy Practices

I, ______________________________ have received a copy of In-Sync Pediatric Therapy Center, LLC's Notice of Privacy Practices with an effective date of August 1, 2007.

Name of Patient: ______________________________________

Address of Patient: ______________________________________

____

____

Signature: ______________________________________ Date: _________________

NOTICE OF PRIVACY PRACTICES

Parent Copy

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

The Health Insurance Portability and Accountability Act of 1996 (HIPPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPAA provides penalties for covered entities that misuse personal health information. As required by HIPPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

***Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.

***Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.

***Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release you PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may

Disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.

We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

*The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

*The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

* The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

* The right to request an amendment to your PROTECTED HEALTH INFORMATION.

*The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

*The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health &Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filling a complaint.

For more information about our Privacy Practices, please contact:

Privacy Official
Jocelyn Mitchelle
In-Sync Pediatric Therapy, LLC
1109 Fayetteville Road
Van Buren, AR. 72956
479-474-6444

For more information about HIPPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
877-696-6775

CANCELLATION POLICY

Parent Copy

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We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to three weeks. We will then have to place you on a waiting list and will fit you back in the schedule as soon as we can.

SICK POLICY

Parent Copy

In order to prevent infection, we are asking that no sick individuals enter our clinic. This includes your children and their siblings, caregivers, and/or yourself. Your child will not be able to obtain the maximum benefit from therapy when they feel sick. Please keep your child or any of the above mentioned people home if they have the following:

- Fever (must be fever free for 24 hours without medication, before returning)
- Yellow or green discharge from the nose
- Persistent cough
- Sore throat
- Vomiting
- Upset stomach/nausea
- Lice
- Diarrhea
- Impetigo/infantigo or staph infection
- Rash
- Conjunctivitis (pink eye)
- Any other infectious diseases (flu, chicken pox, mumps, etc.)
- We must have a release signed by your physician to resume therapy after **ANY** surgery your child may have had.

Our efforts are to prevent the spread of disease to children with low immunity systems. Also, as therapists, if we get sick, is not only affects your child, but many other adults, children, and our own children as well.

**If your child is sick and you need to cancel, please call BEFORE your scheduled appointment time.*

You may contact the clinic or therapist about a possible make up session. We will do our best to accommodate! We appreciate your understanding and cautiousness in this matter.

Parental Consent Form

*** Form must be completed in its entirety or will not be accepted**

Member Name: ____

Member RID #: ____

Member Diagnosis: ____

I (print name of parent/legal guardian), ____

hereby authorize (print name of provider) ____________In-Sync Pediatric Therapy Center____________ to evaluate, as well as provide any subsequent treatment based on the evaluation results for (please check all services that apply) ☐ Physical Therapy, ☐ Occupational Therapy and/or ☐ Speech Therapy for child named above.

____

Signature of Parent/Legal Guardian if a minor

____

Date Signed by Parent/Legal Guardian

____

Relationship to Member

____

Signature of Therapist or Representative of Therapy Group

____

Date Signed by Provider

RECORD RELEASE AUTHORIZATION FORM

Name:____ Birth Date:______________________________

Address:____

Phone:____ Social Security Number:__________________________

☐ **I give permission for In-Sync Pediatric Therapy Center to release my child's records to:**

____

(Name of Facility)

Phone/Fax Number:____

☐ I give ____

(Name of Facility)

Permission to release my child's records to: IN-SYNC PEDIATRIC THERAPY CENTER
1109 Fayetteville Road Van Buren AR 72956 Phone: 479-474-6444 / fax: 479-474-6446

RECORDS REQUESTED:

☐ Physical Therapy Evaluation
☐ Occupational Therapy Evaluation
☐ Speech Therapy Evaluation
☐ Progress Notes
☐ School IEP/Annual Review
☐ Medical History
☐ Hospital Release/Admission
☐ Other ________________________________

______________________________________ ____________________ ____________

Signature *Relation to patient* *Date*