Patient Information

Date: _____

Patient's Name: _____

Date of Birth: _____

Address:

_____

_____

Daytime Phone Number: _____

Work Phone Number:_____(mother)_____(father)

Cell Phone Number:_____

Email Address:_____

Preferred Method of Communication: (Please circle) Email Phone Text

Mother's Name:_____

Father's Name:_____

Insurance and Primary Policy Holder's Date of Birth:_____

Physician's Name:_____

Referral Source:_____

What are your main concerns at this time?

- Fine motor skills
- Gross motor skills
- Self-care skills
- Sensory Integration
- Speech-Language Skills
- Oral Motor Skills
- Attention
- Peer Interaction
- Family Interaction
- Behavior
- Learning Ability
- _____
- _____

Patient Birthing History and Background Information

Name:_____ DOB:_____
Birth Weight:_____
Apgar Score:_____
Was your pregnancy full-term? Yes or No If no, indicate whether premature or postmature_____
Was the delivery vaginal or C-section?_____

Where there any complication during/ surrounding the birthing process?
_____
_____
Were there any difficulties with nursing?
_____
_____

Is there a history of reflux? Yes or No If yes, is (was) your child on any medication to address this problem?_____

Please indicate the approximate age at which your child achieved the skills listed below:

- Sat_____ Crawled_____ Cruised_____
- Walked_____ Said First Words (babbled)_____
- Put two words together_____ Spoke in short sentences_____

Has your child had any of the following?

• Ear infections	Y	N	What age(s)?_____
• Ear tubes	Y	N	What age(s)?_____
• Adenoidectomy	Y	N	What age(s)?_____
• Breathing difficulties	Y	N	What age(s)?_____
• Head injury	Y	N	What age(s)?_____
• Thumb/finger sucking habit	Y	N	What age(s)?_____
• Tonsillectomy	Y	N	What age(s)?_____
• Tonsillitis	Y	N	What age(s)?_____

Has your child ever suffered from seizure activity? Yes or No_____
Has your child ever been hospitalized?
_____
_____
Does your child suffer from any allergies?_____
Is your child on any medications?_____

Is your child currently enrolled in a pre-school or school program? Yes or No
If so,where?_____

When was your child's most recent vision exam?_____
When was your child's most recent hearing exam?_____

Sensorimotor History

Tactile Processing: Does the child:

- Object to being touched? Y N
- Dislike being cuddled? Y N
- Dislike the feeling of certain fabrics? Y N
- Dislike to have his/her socks/shoes on? Y N
- Dislike having his/her face washed? Y N
- Dislike having his/her hair washed/brushed? Y N
- Dislike having his/her teeth brushed? Y N
- Want tags cut out of his/her clothes? Y N
- Dislike playing in messy materials? Y N
- Underreact/ overreact to getting hurt? Y N
- _____
  _____

Auditory Processing: Does the Child:

- Cover his/her ears in reaction to loud sounds? Y N
- Seem under-responsive to noises? Y N
- Miss some sounds? Y N
- Like to make loud noises? Y N
- Become easily distracted by background noises? Y N
- Have a diagnosed hearing problem? Y N
- Have a diagnosed speech problem? Y N
- _____
  _____

Visual Processing: Does the Child:

- Have a diagnosed visual deficit? Y N
- Loose his/her place while reading/writing? Y N
- Display poor eye contact? Y N
- Appear sensitive to light? Y N
- Make reversals during reading/writing? Y N
- _____
  _____

Olfactory and Gustatory Processing: Does the Child:

- Smell non-food items? Y N
- Lick or mouth non-food items? Y N
- React negatively to smell? Y N
- Eat a limited variety of food? Y N
- Seem unaware of tastes or smells? Y N
- Gag, choke, or vomit in reaction to tastes/smells? Y N
- _____

Proprioceptive Processing: Does the Child:

- Love to be held tightly? Y N
- Push hard on people/objects? Y N
- Seek pressure on his/her body? Y N
- Head bang intentionally? Y N
- _____
  _____

Vestibular Processing: Does the Child:

- Always seem to be on the "go?" Y N
- Enjoy spinning activities, but never seems to get dizzy? Y N
- Avoid balance activities? Y N
- Become fearful if their feet leave the ground? Y N
- Appear to be clumsy? Y N
- _____
  _____

Regulatory concerns: Does the child:

- Have difficulty with bowel/bladder training? Y N
- Smear feces? Y N
- Have difficulty with sleeping patterns? Y N
- Have poor appetite control? Y N
- Have difficulty attending? Y N
- Display an unusually high/low energy level? Y N
- Have excessive emotional/behavioral outbursts? Y N
- _____
  _____

Muscle Tone: Does the child:

- Tire/ fatigue quickly? Y N
- Display poor muscle strength? Y N
- Prop his/her head up when writing/drawing? Y N
- Prefer to lie on his/her back rather than their stomach? Y N
- Prefer sedentary activities? Y N
- Display a weak grasp on writing or eating utensils? Y N
- Hold his/her mouth open unnecessarily? Y N
- _____
  _____

Additional Comments:

_____
_____
_____

Speech-Language-Hearing History

Do you feel your child has a speech problem? Y N
If yes, please describe._____
_____

Do you feel your child has a hearing problem? Y N
If yes, please describe._____
_____

Has your child ever had speech-language therapy? Y N
If yes, where and when?_____
What was he/she working on?_____
_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____
_____
What do you see as your child's most difficult problem in home?_____
_____
What do you see as your child's most difficult problem in school?_____
_____
Is there a language other than English spoken in the home? Yes or No
If yes, which one?_____
Does the child speak the language? Yes or No
Does the child understand the language? Yes or No
Who speaks the language? _____
Which language does the child prefer to speak at home? _____

Does your child:

- Repeat sounds, words, or phrases over and over? Y N
- Understand what you are saying? Y N
- Retrieve/point to common objects upon request (ball, cup, shoe)? Y N
- Follow simple directions ("Shut the door" or "Get your shoes")? Y N
- Respond correctly to yes/no questions? Y N
- Respond correctly to who/what/where/when/why questions? Y N

Your child currently communicates using:

- Body language Y N
- Sounds (vowels, grunting) Y N
- Words (shoe, doggy, up) Y N
- 2 to 4 word sentences Y N
- Sentences longer than four words Y N
- Other_____

Behavioral Characteristics:

- Cooperative Y N
- Attentive Y N
- Willing to try new activities Y N
- Plays alone for reasonable length of time Y N
- Separation difficulties Y N
- Easily frustrated/impulsive Y N
- Stubborn Y N
- Restless Y N
- Poor eye contact Y N
- Easily distracted/short attention Y N
- Destructive/aggressive Y N
- Withdrawn Y N
- Inappropriate behavior Y N
- Self-abusive behavior Y N

Additional Comments:

_____

_____

_____

Financial Policy

1. Payment is expected at the time services are rendered. We accept cash and checks. In the case that legal action is instituted to collect such fees due to failure to pay, I agree to pay in addition to the costs and disbursements provided by statue such sum as the court may adjudge reasonable as attorney's fees in said action.

2. If you must cancel a therapy session, it is necessary that you give 24-hour advance notice (except in the case of emergency or sudden illness.) If a 24-hour notice is not given, you will be charged for the entire therapy session. If there are three unauthorized cancellations, your services at Pediatric Therapy Solutions, Inc. will be terminated.

3. I have read and accept the financial policies of Pediatric Therapy Solutions, Inc. I authorize Pediatric Therapy Solutions, Inc. to provide therapeutic services for:

_____
Patient's Name

_____ _____
Signature (Client, parent, guardian, responsible party) Date

_____
Print name of Signature

Illness Policy

If your child is ill, please keep them at home for 24 hours after the symptoms have disappeared.

This includes, but is not limited to:

- Fever and/or Flu-like symptoms
- Vomiting
- Diarrhea
- Constant runny nose (allergies not included)
- Head Lice
- Skin Rash (unless you have a doctor's note stating otherwise)

_____ _____

Signature (Client, parent, guardian, responsible party) Date

_____

Print name of Signature

Consent to Treatment Form

PATIENT'S NAME: _____

CONSENT TO MEDICAL TREATMENT –

I, the undersigned, whether acting as agent or patient, voluntarily consent to therapy as determined to be necessary or beneficial in the professional judgment of my physician or therapist. I acknowledge that no guarantees have been made to me as to the effect of such treatment on my condition.

CONSENT FOR RELEASE OF MEDICAL INFORMATION –

I, the undersigned, whether acting as agent or patient, consent to the release of my medical records to my doctor and to my insurance company.

FINANCIAL AGREEMENT –

I, the undersigned, whether acting as agent or patient, agree that in consideration for the services rendered or to be rendered do hereby assign payment directly to Pediatric Therapy Solutions. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

This assignment is irrevocable.

This document has been fully explained to me. I certify that I understand its comments and agree to it freely and that I am the patient or I am duly authorized as the patient's agent or representative to execute the above.

_____ _____

Signature (Client, parent, guardian, responsible party) Date

_____ _____

Print Name of Signature Describe Relationship

_____ _____

Witness Date

Pediatric Therapy Solutions, Inc.

Authorization for Release of Information

I, _____, authorize Pediatric Therapy Solutions, Inc. to release
(Client, parent, guardian, responsible party)

Information regarding _____ among the following:
(Patient)

Educators _____

Caregivers _____

Physicians _____

Speech Language Pathologist _____

Occupational Therapist _____

Physical Therapist _____

Psychologists _____

Nutritionist _____

Chiropractor _____

Behavior Therapist _____

Early Intervention _____

Other _____

_____ _____
Signature (Client, parent, guardian, responsible party) Date

_____
Print Name of Signature

PEDIATRIC THERAPY SOLUTIONS, INC.
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. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer who is Michelle Matteoli Adams, OTR/L

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 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 or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who 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 and disclosed to pay your health care bills and to support the operation of your therapist's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review

activities, training of therapy students, licensing, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public

or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your therapist and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If your therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed for an emergency. With this in mind, please discuss any restriction you wish to request with your therapist in a written statement.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your therapist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes

other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may file a complaint with us if you feel your privacy rights have been violated by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Michelle Matteoli Adams, OTR/L** at (941) 360-0200 **or Michelle@PediatricTherapySolution.com** for further information about the complaint process.

This notice was published and becomes effective on **April 1, 2010.**

Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's notice of Privacy Practices.

_____ _____

Signature (Client, parent, guardian, responsible party) Date

_____

Print name of Signature

Photography Consent for Minors for Marketing

I hereby grant permission to Pediatric Therapy Solutions, Inc. to take and use photographs, video, and/or digital images of _____for use in Web sites or other electronic communications, news releases and/or educational materials.

I authorize the use of these images without compensation to me. All negatives, prints, video, and digital reproductions shall be the property of Pediatric Therapy Solutions, Inc.

_____
Parent/ Guardian Name

_____
Signature

_____
Date