HARRIS PEDIATRIC THERAPY

CHILD'S NAME: _____ DATE OF BIRTH: _____

Please initial and date the following authorizations and sign at the bottom

1. AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status.
Initial _____ Date _____

2. AUTHORIZATION TO PHOTOGRAPHY/VIDEO

I, the legal parent/guardian of the above said child, give Harris Pediatric Therapy permission to take photographs/videotape of my child. These photographs may be used for marketing purposes (brochures, mailers, commercials) educational and instructional purposes, or appear within the clinic.
Initial _____ Date _____

3. AUTHORIZATION FOR EVALUATION AND TREATMENT

I, the legal parent/guardian of the above said child, hereby authorize and request the performance of therapeutic evaluation and/or treatment services by Harris Pediatric Therapy and its associated therapists in the areas of physical, occupational, or speech therapy as ordered by my child's physician.
Initial _____ Date _____

4. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the legal parent/guardian of the above said child, do hearby give my permission to Harris Pediatric Therapy to use my child's medical record for any purpose deemed necessary.
Initial _____ Date _____

5. PAYMENT AUTHORIZATION AND FINANCIAL AGREEMENT

I authorize payment of medical benefits to be made directly to Harris Pediatric Therapy. I agree to either fully pay or set up a payment plan within 30 days of any invoice. I agree to be fully responsible for charges, regardless of my insurance company's coverage or lack of coverage of charges.
Initial _____ Date _____

6. MEDICAL/LIFESAVING CONSENT

If I, the legal parent/guardian of the above said child, cannot be reached, I authorize the administration of "life saving" procedures such as transport, hospitalization, medication, surgery, x-rays, etc. deemed necessary by a medical professional.
Initial _____ Date _____

7. TRANSPORTATION CONSENT

I authorize employees of Harris Pediatric Therapy to transport the said child to and from the treatment site to my home address or child's school.
Initial _____ Date _____

8. CONSENT FOR CHILD OBSERVATION/STUDENT INTERACTION

I, the legal parent/guardian of the above said child, understand that Harris Pediatric Therapy is a teaching facility. I give permission for my child to be observed and/or treated by a student through supervised observation undertaken as part of an academic internship, practicum, and/or observation requirement for students.
Initial _____ Date _____

_____

Parent or Guardian Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Practices from time to time and that I may contact this organization at any time to obtain a copy of the Notice of Privacy Practices. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action on this consent.

Name……..

Relationship to Patient ……..

Signature……

Date……

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

CLIENT NAME _____ MAILING ADDRESS _____

DOB _____

I, _____ , hereby authorize the following _____ to disclose
(name of provider/plan, e.g. doctor, insurance)

From the records of the above named client to:

HARRIS PEDIATRIC THERAPY
2403 Main Drive, #5
Fayetteville, AR 72704
Phone (479) 966-4883
Fax (479) 445-6130

For the specific purpose of PHYSICAL THERAPY, OCCUPATIONAL THERAPY OR SPEECH THERAPY EVALUATION AND TREATMENT.
"All medical records" includes any and all written information you may have concerning my health care and any illness or injury that I may have suffered, including but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital records pertaining to me.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the purpose of time needed to fulfill its purpose for up to one year, except for disclosures of financial transactions, wherein the authorization is valid indefinitely.

I understand that I can revoke this authorization at any time with written notification. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requestor of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided by state or federal law.

I understand that if my record contains information related to HIV infection, AIDS, or AIDS related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or women's, infant, and children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization, and will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits. However, if a service is requested by a non-treatment provider (i.e. insurance company), for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given.

If treatment is research related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization; a copy of this authorization shall be as binding as the original.

Signature of Client/ Guardian Date Relationship to client

HARRIS
PEDIATRIC THERAPY

ADMISSION DATE	PRIMARY LANGUAGE	PRIMARY/SECONDARY DISABILITY
CHILD'S NAME	DATE OF BIRTH	AGE
SEX/RACE	CHILD'S SOCIAL SECURITY NUMBER	PHYSICIAN
CHILD'S ADDRESS	CITY, STATE, and ZIP	IS YOUR CHILD IMMUNIZED?
TELEPHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS
EMERGENCY CONTACT (OTHER THAN PARENT): NAME, ADDRESS, PHONE NUMBERS, RELATIONSHIP TO PATIENT		
FATHER'S NAME	AGE	OCCUPATION
MOTHER'S NAME	AGE	OCCUPATION
SIBLINGS IN THE HOUSE? Y/N HOW MANY?	FAMILY HISTORY OF _ ADHD _ Learning Disabilities _ Autism/PDD _ Communication Disorders _ Hearing Loss	ARE PARENTS _ Living together _ Separated _ Divorced _ Remarried _ Married

FUNDING

Primary Insurance Company _____
ID/ Policy Number _____
Group Number _____
Full Name of Policy Holder _____
Date of Birth of Policy Holder _____
SSN of Policy Holder _____
PCP _____

AR Medicaid Number _____
Effective Date _____
AR Kids A Number _____
AR Kids B Number _____
PCP _____

PREGNANCY AND BIRTH HISTORY

	YES	NO	COMMENTS
Were there any illnesses, injuries, bleeding or other complications during this pregnancy?			If yes, please describe:
Was this pregnancy full term?			Please list gestational age and weight at birth.
Was labor and delivery normal?			Vaginal or Cesarean (Circle One)
Were forceps/vacuum extractor used?			If yes, please describe:
Was there a need for oxygen or respiratory assistance?			If yes, please describe:

MEDICAL HISTORY

HAS YOUR CHILD HAD ANY OF THE FOLLOWING?	YES	NO	COMMENTS/ APPROXIMATE DATE
Frequent ear infections? Does your child have PE tubes?			
Reflux or difficulty keeping food down? Please describe. Does your child have irritability following feedings? Are there current or previous feeding or swallowing difficulties? Please describe.			
Cleft Palate? If repaired, please give date.			
Does your child have vision problems? Please give date of last vision screening.			
Does your child have a hearing problem? Please give date of last hearing screening.			

HAS YOUR CHILD BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?	YES	NO	COMMENTS/ APPROXIMATE DATE
Autism			
PDD			
Asperger's syndrome			
Apraxia of Speech			
Dysphagia			
ADD/ADHD			
Down syndrome Has he/she been diagnosed with Atlantoaxial instability? Are there any movement restrictions?			
Cerebral Palsy			
Seizure Disorder			
Spina bifida			
Muscular Dystrophy			
Traumatic Brain Injury			
Other genetic disorder			
Congenital anomalies			
Brachial Plexus injury			
****Allergies (Please specify)****			
****PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING****			

GROWTH AND DEVELOPMENT

	YES	NO	COMMENTS
Did your child bottle feed or breast feed?			
Did your child have sucking difficulties?			
Are there any issues with sleep patterns? If so, please explain.			

We understand that you may have forgotten exact ages when these milestones occurred. If your child has not achieved a skill but is actively learning it, please mark the skill as emerging.

WHAT AGE DID YOUR CHILD	APPROXIMATE AGE	COMMENTS	EMERGING SKILL
Roll over?			
Crawl?			
Sit Independently?			
Walk independently?			
Speak first word?			
Speak two word sentences?			
Drink from a cup?			
Use a spoon?			
Dress independently?			
Toilet train?			

DESCRIBE YOUR CHILD'S BEHAVIOR	YES	NO	N/A	COMMENTS
Is mostly quiet				
Is overly active				
Tires easily				
Talks constantly				
Impulsive				
Aggressive or fights frequently				
Resistant to change				
Has difficulty separating from caregiver				
Has nervous habits or tics				
Has poor attention span				
Usually happy				
Has frequent tantrums				
Frustrated easily				
Rocks him/herself frequently				
Avoids touch				
Craves touch				

EDUCATIONAL BACKGROUND

	YES	NO	COMMENTS
Does your child attend school/ preschool? Where? How often? What grade?			
Does your child receive special education or therapies at school? (OT, PT, ST) Please specify.			
May we communicate with school staff?			

THERAPY CONCERNS

READ THE QUESTIONS AND CHECK THE APPROPRIATE BOX	EXTREMELY CONCERNED	VERY CONCERNED	MODERATELY CONCERNED	MILDLY CONCERNED	NOT CONCERNED
Your child's fine motor movement (movement with hands, etc.)?					
Your child's gross motor movement (full body movement)?					
Your child's speech and language development?					
Your child's sensory behaviors?					
Your child's social behaviors?					
Your child's mobility?					
Your child's feeding?					
Your child's progress at school?					

Please describe any additional concerns or comments you may have that were not discussed in the information above.