PEDIATRIC
THERAPY ASSOCIATES

WELCOME TO PEDIATRIC THERAPY ASSOCIATES!

Thank you for choosing our team of professionals to meet your child's speech-laguage needs. We know there are many options from which to choose and appreciate you selecting us to assist with this important process.

Please review and complete the New Client Information Packet. The packet includes forms that will provide relevant information regarding your child's developmental and medical history. Also included are forms explaining our privacy and financial policies. We understand that these forms can be time consuming, however it is important that we have as much information as possible so that we may provide the best services for your child.

Upon completion of the New Client Information Packet, please bring the packet to your child's Speech Evaluation appointment or fax them to our office at 904-249-8893.

We look forward to meeting your child!

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REHABILITATION SERVICES INFORMATION

Please print clearly and answer all questions completely.

Date: _____

Name: _____ Birthdate: _____ Sex: ○ M ○ F

Mailing Address:_____ Apt/Lot:_____

City: _____ State: _____ Zip:_____

SSN: _____ Marital Status: Choose one:

Home Phone:_____ Work Phone: _____ Ext: _____

Email Address: _____

Employer Name: _____

Employer Address: _____

Emergency Contact / Phone: _____

Circle One: ○ Full Time ○ Part Time ○ Student ○ Unemployed ○ Retired ○ Disabled

Referred by (M.D.)_____

Primary Care Physician: _____

Reason for Visit / Symptoms: _____

Date of Onset/Symptoms/Accident: _____

Are you filing with Workers Comp or Auto Insurance? ○ Y ○ N

Do you have an attorney for this accident? ○ Y ○ N

If yes, Attorney Name / Phone _____

Have you ever had physical, chiropractic, occupational, or speech therapy before?

○ Y ○ N If yes, where and why? _____

Primary Insurance Company: _____

Ins. Co. Phone: _____ Insured Name: _____

Policy #:_____ Group #: _____

Secondary Insurance Company: _____

Ins. Co. Phone: _____ Insured Name: _____

Policy #:_____ Group #: _____

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PATIENT HISTORY FORM

Identifying and Family Information:

child's Name _____ Birthdate _____ Sex ❑ M ❑ F
Fathers Name _____ Daytime Phone _____
Address _____ Cell Phone _____
_____ Email _____
_____

Mother's Name _____ Daytime Phone _____
Address _____ Cell Phone _____
_____ Email _____
_____

Doctor's Name _____ Doctors Phone _____

Child lives with (check one):

❑ Birth Parents ❑ Foster Parents ❑ One Parent
❑ Adoptive Parents ❑ Parent and Step-Parent ❑ Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Child's race/ethnic group:

❑ Caucasian ❑ Hispanic ❑ African American
❑ Native American ❑ Asian or Pacific Islander ❑ Other _____

Is there a language other than English spoken in the home? ❑ Yes ❑ No

If yes, which one? _____
Does the child speak the language? ❑ Yes ❑ No
Does the child understand the language? ❑ Yes ❑ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

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SPEECH - LANGUAGE - HEARING

Do you feel your child has a speech problem? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Do you feel your child has a hearing problem? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Has he/she ever had a speech evaluation/screening? ❑ Yes ❑ No

If yes, where and when?: _____

What were you told?: _____

_____

Has he/she ever had a hearing evaluation/screening? ❑ Yes ❑ No

If yes, where and when?: _____

What were you told?: _____

_____

Has your child ever had speech therapy? ❑ Yes ❑ No

If yes, where and when?: _____

What was he/she working on?: _____

_____

Has your child received any other evaluation or therapy? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Is your child aware of, or frustrated by any speech language difficulties? _____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

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BIRTH HISTORY

Was there anything unusual about the pregnancy or birth? ❑ Yes ❑ No

If yes, please describe: _____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ❑ Yes ❑ No

If yes, please describe: _____

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ❑ Yes ❑ No

If the child stayed at the hospital, please describe why and how long:

_____

_____

MEDICAL HISTORY

Has your child had any of the following?

❑ adenoidectomy
❑ allergies
❑ breathing difficulties
❑ chicken pox
❑ colds
❑ ear infections
How often? _____
❑ ear tubes
❑ encephalitis
❑ flu
❑ head injury
❑ high fevers
❑ measles
❑ meningitis
❑ mumps
❑ scarlet fever
❑ seizures
❑ sinusitis
❑ sleeping difficulties
❑ thumb/finger sucking habit
❑ tonsillectomy
❑ tonsillitis
❑ vision problems

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ❑ Yes ❑ No

If yes, why? _____

_____

Please list any medications your child takes regularly? _____

_____

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DEVELOPMENTAL HISTORY

Please list approximate age in years and/or months your child achieved the following developmental milestones:

Gross Motor

_____ sat alone
_____ crawled
_____ pulled up
_____ stood alone
_____ cruised
_____ walked

Speech/Language

_____ smiled
_____ babbled
_____ said first word
_____ put two words together
_____ spoke in short sentences

Does your child....

- ☐ Choke on food or liquids?
- ☐ Currently put toys/objects in his/her mouth?
- ☐ Brush his/her teeth and/or allow brushing?

Does your child....

- ☐ Repeat sounds, words or phrases over and over?
- ☐ Understand what you are saying?
- ☐ Retrieve/point to common objects upon request (i.e. ball, cup, shoe)?
- ☐ Follow simple directions ("close the door" or "get your shoes")?
- ☐ Respond appropriately to yes/no questions?
- ☐ Respond appropriately to who/what/when/where/why questions?

Your child currently communicates using....

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

Behavioral Characteristics:

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

Vision:

Vision tested? _____ If yes, date of last vision test: _____
Vision tested by: _____ Results of vision test:_____

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FINE MOTOR AND UPPER EXTREMITY

Is your child:

- ☐ Right Handed
- ☐ Left Handed
- ☐ Not yet established (uses both hands) _____

Does your child have trouble with:

- ☐ Holding toys
- ☐ Puzzles
- ☐ Holding a pencil/crayon
- ☐ Scissor skills
- ☐ Writing

Comments:_____

Please check the types of play your child engages in most often:

____ throwing and shaking toys ____ games with rules ____ rough and tumble play ____ make believe play
____ banging toys together ____ mouthing toys ____ pushing/pulling toys ____ looking at books

ACTIVITIES OF DAILY LIVING

Does your child independently dress/undress his/her:

- ☐ Jacket
- ☐ Shirt
- ☐ Pants
- ☐ Socks
- ☐ Shoes

If not, what help does he/she require: _____

Does your child independently fasten/unfasten:

- ☐ Buttons
- ☐ Zippers snaps
- ☐ Shoelaces

If not, what help does he/she require: _____

Does your child independently use a:

- ☐ Spoon
- ☐ Fork
- ☐ Open cup
- ☐ Straw

If not, what help does he/she require: _____

Is your child toilet trained:

- ☐ Yes
- ☐ No

If yes, at what age were they toilet trained: _____

Describe your child's favorite activities: _____

_____

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SENSORY PROCESSING

Does your child seem unusually sensitive to:

- ☐ Having hair washed
- ☐ Having face/body washed
- ☐ Having teeth brushed
- ☐ Having nails trimmed
- ☐ Tags on clothing
- ☐ Hearing loud noises
- ☐ Being hugged/touched by others
- ☐ Certain foods/picky eater
- ☐ Movement (swings)

How long can your child attend to a difficult task? (give examples) _____

_____

Does your child have unusual sleep patterns? _____

If yes, please describe: _____

Does your child seek out:

- ☐ Rocking
- ☐ Jumping
- ☐ Crashing
- ☐ Biting/mouthing toys
- ☐ Spinning
- ☐ Repetitive activities
- ☐ Climbing
- ☐ Head banging

Does your child appear:

- ☐ Insensitive to pain
- ☐ Clumsy
- ☐ Distracted by sounds
- ☐ Distracted by lights
- ☐ Easily frustrated
- ☐ Aggressive

Does your child have difficulty with transitions/changes in environment? _____

If yes, please give examples: _____

_____

Additional comments:

_____

_____

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SCHOOL HISTORY

If your child is in school, please answer the following:

Name of school and grade in school? _____

_____

Teacher's name? _____

_____

Has you child repeated a grade?_____

_____

What are your child's strengths and/or best subjects? _____

_____

Is your child having difficulty with any subjects?_____

_____

Is your child receiving help in any subjects? _____

_____

ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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CONSENT FOR MEDICAL TREATMENT OF A MINOR

I the undersigned, am the patient or the patient's duly representative, do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary in the judgement of my physician, his/her designee for Myself _____, My minor child _____, Other _____. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or evaluations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

_____

Patient or Responsible Guardian Date

_____

Patient or Responsible Guardian Date

TELEPHONE CONSENT

_____

Person Giving Consent Relationship

_____

Witness Date

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RECEIPT OF NOTICE OF INFORMATION PRACTICES

I acknowledge receipt of Pediatric Therapy Associates Care Notice of Informational Practices.

I agree ◯ object ◯ to disclosure of the patient's location in the facility, general condition and religious affiliation (available to clergy only) in the Facility Directory.

I agree ◯ object ◯ to disclosure of the patient's health information to a family member or close personal friend, including clergy, who is involved in my care.

_____

Patient's Name or Responsible Party Date

_____

Signature

TO BE COMPETED BY PROVIDER PERSONNEL

A good faith effort was made to obtain written acknowledgement of the Notice of Information Practices.

☐ Written acknowledgement was obtained

☐ Written acknowledgement was not obtained. Below the efforts to obtain the acknowledgement and reason not obtained are described.

_____

_____

_____

_____

Provider Name Date

_____

Signature

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FINANCIAL POLICIES

1. Financial Policy _____ Initial

I understand that in consideration of the services rendered to the patient, I am directly responsible for payment of services rendered at Pediatric Therapy Associates. I understand Pediatric Therapy Associates will obtain a verbal approval from my insurance company to verify benefits prior to treatment. Verbal approval is not a guarantee of payment. A written explanation of payment is the only guarantee of coverage for services rendered. If the insurance carrier should pay a claim in error, the balance due for services is the responsibility of the guarantor. Payment of deductibles or co-payments is due in full at the time of service.

2. Cancellation Policy _____ Initial

A 24 hour notice of cancellation is required for all scheduled appointments. A fee of $50.00 will be applied for all cancellations made without 24 hours notice. If your child is sick, we require a cancellation call no later than 8:00am the day of the scheduled appointment. This notice is necessary so that cancelled therapy times can be utilized for other clients in need of treatment. We thank you for you understanding in this matter.

3. Returned Check Policy _____ Initial

A fee of $25.00 dollars will be charged for any returned check. Once a check is returned, credit/debit card payment or cash payment will be required.

By signing the following, I agree to the above policies.

Guarantor Signature _____

Print Name _____

Date _____

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OFF SITE THERAPY

Credit Card Authorization

Cardholder Name _____Security Code _____

Billing Address _____

_____

I authorize charges to this credit card for any service provided by Pediatric Therapy Associates not covered by insurance. This includes, but is not limited to deductible charges and co-payments.

Credit Card (circle one) Visa Mastercard Discover

Card Number _____ Expiration Date _____

_____ Date _____
Patient/Parent/Guardian Signature

Email address on file _____

Pediatric Therapy Associates
904.249.8893 Jacksonville

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PARENT STATEMENT

_____ is NOT receiving speech therapy in the school system at this time.

_____ is on the waiting list to be tested for speech therapy services in the school system.

_____ IEP attached.

Parent Signature: _____

Date: _____

Name: _____

DOB: _____

Sponsor ID: _____