PEDIATRIC
THERAPY ASSOCIATES

# 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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FORM 3-2.

## Adult Case History Form

**General Information**

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip Code: _____

Occupation: _____ Business Phone: _____

Employer: _____

Referred by: _____ Phone: _____

Address: _____

Family Physician: _____ Phone: _____

Address: _____

Single _____ Widowed _____ Divorced _____ Spouse's Name: _____

Children (include names, gender, and ages):

_____

_____

_____

_____

Who lives in the home?

What languages do you speak? If more than one, which one is your dominant language?

What was the highest grade, diploma, or degree you earned?

*(continues)*

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## FORM 3-2. Continued

Describe your speech-language problem.

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Have you seen any other speech-language specialists? Who and when? What were their conclusions or suggestions?

Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions.

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

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## FORM 3-2. Continued

**Medical History**

Provide the approximate ages at which you suffered the following illnesses and conditions:

| | | |
|---|---|---|
| Adenoidectomy _____ | Asthma _____ | Chicken pox _____ |
| Colds _____ | Croup _____ | Dizziness _____ |
| Draining ear _____ | Ear infections _____ | Encephalitis _____ |
| German measles _____ | Headaches _____ | Hearing loss _____ |
| High fever _____ | Influenza _____ | Mastoiditis _____ |
| Measles _____ | Meningitis _____ | Mumps _____ |
| Noise Exposure _____ | Otosclerosis _____ | Pneumonia _____ |
| Seizures _____ | Sinusitis _____ | Tinnitus _____ |
| Tonsillectomy _____ | Tonsillitis _____ | Other _____ |

Do you have any eating or swallowing difficulties? If yes, describe.

List all medications you are taking.

Are you having any negative reactions to these medications? If yes, describe.

Describe any major surgeries, operations, or hospitalizations (include dates).

*(continues)*

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## FORM 3-2. Continued

Describe any major accidents.

Provide any additional information that might be helpful in the evaluation or remediation process.

Person completing form: _____

Relationship to client: _____

Signed: _____ Date: _____

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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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## 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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## CONSENT FOR MEDICAL TREATMENT

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