Center for Pediatric Therapy

INTAKE QUESTIONS - Developmental

DATE:_____

CHILD'S NAME:_____ DATE OF BIRTH: _____

MOTHER'S NAME:_____ MOTHER'S AGE:_____

FATHER'S NAME:_____ FATHER'S AGE:_____

If child does not live with parents, please indicate who they live with:

Child lives with: ☐Guardian(s) ☐Foster Parent(s) ☐Other _____

NAME: _____

NAME: _____

FULL ADDRESS where child resides: _____City_____ZIP_____

FULL MAILING ADDRESS if different from above: _____City_____ZIP____

PHONE NUMBERS (Please mark with numbers the order to call):

HOME: _____ NAME/CELL: _____

NAME/CELL: _____ NAME/WORK: _____

NAME/WORK:_____

EMER. CONTACT NAME:_____ PHONE #:_____ RELATIONSHIP:_____

Would you like to receive appointment reminder texts? ☐ Yes ☐ No

Carrier_____ Phone# _____

Would you like to receive appointment reminder emails ? ☐ Yes ☐ No

Email Address: _____

PRIMARY CARE PHYSICIAN:_____

SERVICES INTERESTED IN RECEIVING:

☐ Occupational Therapy ☐Physical Therapy ☐Speech Language Therapy ☐ Feeding Therapy

REASON FOR SEEKING EVALUATION/TREATMENT:

_____

What I would like therapy to help my child with: (must be completed)

_____

_____

MEDICATIONS (and what they are for):

_____

_____

ALLERGIES:

_____

☐ Official testing has been completed Approximate age:_____

PRECAUTIONS/CONTRAINDICATIONS/OTHER THINGS WE SHOULD KNOW:

_____

_____

MEDICAL HISTORY:

Yes No

☐ ☐ Diagnoses (please list):_____

☐ ☐ Vision concerns:_____

☐ ☐ Wears glasses If yes, what is the correction for:_____

☐ ☐ Hearing concerns:_____

Testing results:_____ Date:_____

☐ ☐ Ear Infections How many:_____ PE Tubes (date):_____

☐ ☐ Hospitalizations (why/approximate age):_____

_____

_____

☐ ☐ Medical tests, surgeries, x-rays, MRI's, labs (procedure and approximate age):

_____

_____

_____

PREGNANCY:

Mother's health during pregnancy (include bed rest, pre-term labor, gestational diabetes, etc.):

_____

List Medications or Other Substances taken during pregnancy:_____

Other information about the pregnancy not listed above:_____

_____

DELIVERY:

General health of the baby during delivery:_____

Other information about the delivery:_____

_____

AFTER DELIVERY:

Yes No

☐ ☐ Respiratory Complications:_____

☐ ☐ Ventilator If yes, how long:_____

☐ ☐ Oxygen needed If yes, how long:_____

☐ ☐ NICU stay If yes, how long:_____

☐ ☐ Feeding Difficulties If yes, please describe:_____

☐ ☐ Reflux

☐ ☐ Other not listed – Please describe:_____

_____

_____

OTHER DEVELOPMENTAL SERVICES at OTHER CLINICS

Occupational Therapist_____ Clinic _____

Physical Therapist_____ Clinic _____

Speech Therapist_____ Clinic_____

OTHER SERVICES

Please list any other professionals and agencies who are currently seeing or have seen your child:

CPS Case Worker & Phone #_____

Infant Toddler Network_____

Neurologist_____

Gastroenterologist_____

Ear, Nose, Throat (ENT)_____

Other Specialist Physician_____

Mental Health/Behaviorist_____

Audiologist_____

Nutritionist/Dietician_____

Public Health Nurse_____

Other_____

FAMILY AND HOME SITUATION

Other children in the home (list names and ages):_____

_____

Who does your child spend most of his/her time with?_____

Describe how your child interacts/plays with others at home and other places:_____

_____

Does your family have a religious preference?_____

Yes	No			
☐	☐	Does your child attend Daycare?	Where_____	How Often_____
☐	☐	Does your child attend Preschool?	Where_____	How Often_____
☐	☐	Does your child attend a Play Group?	Where_____	How Often_____

If child is in Foster Care:

When was first placement? _____

What placement are you? _____

Other information we should know? _____

_____

_____

Other Agencies involved in this case? _____

GAL/CASA Name: _____ **Phone Number:**_____

Center for Pediatric Therapy

Patient Authorization Form

Patient Name:	**Date of Birth:**

Release of Information and Consent to Treat

I am aware of my child's diagnosis and wish to receive treatment at Center for Pediatric Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Center for Pediatric Therapy and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided.

Initial: _____

Assignment of Benefits

I authorize payment directly to Center for Pediatric Therapy for services. This is a direct assignment of rights and benefits. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

Notice of Privacy Practices (HIPAA Acknowledgement and Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Center for Pediatric Therapy. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations.

Initial: _____

Payment Guarantee

I agree to pay Center for Pediatric Therapy for the services provided to my child. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification for is only an explanation of coverage as quoted by my insurance company and it is not a guarantee of coverage or payment. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment and services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Center for Pediatric Therapy.

Initial: _____

Parent/Guardian Signature:	**Date:**

Center for Pediatric Therapy

Insurance/Guarantor Information

_____ _____
(PATIENT NAME) (DOB)

INSURANCE INFORMATION

Primary Insurance Company and Phone# _____

Insurance ID#: _____ Group#: _____

Guarantor: _____ SSN: _____ DOB: _____
(or responsible parent)

Employer Name: _____ Relationship to Patient: _____

****

Secondary Insurance Company and Phone# _____

Insurance ID#: _____ Group#: _____

Guarantor: _____ SSN: _____ DOB: _____
(or responsible parent)

Employer Name: _____ Relationship to Patient: _____

_____
Other information:

Center for Pediatric Therapy

PRIVATE AND STATE INSURANCE COVERAGE CHANGES

If you have changes in insurance, we need to be notified in advance so that we can determine coverage and need for prior authorization.

Initial: _____

If your child is covered, partially or in full, by state insurance, it is your responsibility to provide us with any new coverage information by the first visit of each month when any changes occur. **Because it is the insurance that you carry for your child and it renews on a monthly basis, we require that you bring in the updated insurance information by the first visit of the new month if it has changed.** Otherwise, we will be unable to see you for that visit.

Initial: _____

For many public assistance programs and private insurances, we are required to obtain authorization prior to the patient's appointment. **Without current insurance information (i.e. current/new ID card, etc), we are unable to do so and your child's treatment may be affected.**

We welcome any updated information to be faxed to us at (509) 487-3025. Please call with any questions or concerns.

By signing below, I acknowledge that I have read the above policy and understand it.

PATIENT'S NAME _____ TODAY'S DATE _____

PARENT/GUARDIAN SIGNATURE _____

PRINT NAME _____

6710 N Country Homes Boulevard
Spokane WA 99208

(p) 509-487-2958
(f) 509-487-3025

Center for Pediatric Therapy

CANCELLATION/NO SHOW/TARDINESS POLICY

Dear Parents/Guardians,

Thank you for choosing Center for Pediatric Therapy for your child's care. The policies written below are designed to improve our ability to see all of our patients and to provide complete and consistent treatment for your child. We hope that these policies will improve our overall service to our patients. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your appointments:

1. Therapists often are not able to wait more than 15 minutes for a late appointment. **Please notify your therapist or the front office as soon as you know you will be late.** Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, the session will end at the regularly scheduled time.

2. If you need to cancel your child's appointment, our clinic requires that you **cancel 24 hours in advance**, except in emergency or illness situations.

3. If you have **three consecutive cancellations** of your child's appointments or you **miss more than ½ of your scheduled appointments**, you **may lose your standing appointment** time slot. Additionally, your child **may be placed on hold** for therapy. You and your child's primary care physician will be notified by phone or letter of such circumstances.

4. If your child does not attend their scheduled appointment and you have not called to give notification that the session would be missed, you will be considered a "No Show". If you have **two No Shows** for scheduled appointments, your child **will be discharged from all current therapy services** and you and your child's primary care physician will be notified.

Please feel free to speak with your therapist about any concerns you may have about these policies, or to discuss your regularly scheduled appointment time if you know that your current scheduled time is not optimal. We will do everything possible to provide you with a time that is consistently available for both you and your therapist. Thank you for your cooperation.

By signing below, I acknowledge that I have read the above policy and understand it.

PATIENT'S NAME _____ TODAY'S DATE _____

PARENT/GUARDIAN SIGNATURE _____

PRINT NAME _____

6710 N Country Homes Boulevard
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Center for Pediatric Therapy

WELLNESS POLICY

The health and wellness of your child and our staff is very important to us. Because of this, we have developed a health care plan to assist in ensuring that we all can help take care of each other by taking care of health concerns.

We will not be able to have your child receive therapy for the day until the following symptoms are gone for at least 24 hours:

- Fever (100 degrees or higher)
- Nasal or ear discharge that is other than clear (i.e. yellow, green or thick consistency)
- Severe/continual cough
- Severe sore throat or strep throat
- Severe earache
- Vomiting or diarrhea (3 or more times in a 24-hour period)
- Pink eye
- Lice
- Unknown or contagious rash
- Any other contagious illness
- Any communicable disease

We will begin therapy earlier only if accompanied by a doctor's note releasing your child back to therapy as no longer being contagious. If your child becomes ill while in therapy, he/she will need to be taken home.

These precautions are taken for the health and safety of your child, other children and the staff at Center for Pediatric Therapy. If your child is exposed to a contagious illness, please inform the staff as soon as possible so we will be able to alert families and staff that may have also been exposed. We will post a notice informing other parents of the contagious disease and keep your child's identity anonymous.

By signing below, I acknowledge that I have read the above policy and understand it.

PATIENT'S NAME _____ TODAY'S DATE _____

PARENT/GUARDIAN SIGNATURE _____

PRINT NAME _____

6710 N Country Homes Boulevard
Spokane WA 99208

(p) 509-487-2958
(f) 509-487-3025

Center for Pediatric Therapy

PHOTO RELEASE FORM

Patient Name: _____

Patient Date of Birth: _____

I, _____,

___ do

___ do not

grant permission to Center for Pediatric Therapy, LLC and its agents or employees to use photographs and/or video of me and/or my child for use in promotional and educational materials such as brochures, websites, home exercise programs, and advertisements. In giving my consent, I hereby release and hold harmless, Center for Pediatric Therapy, LLC, their employees, agents and designees from any and all responsibility or liability. I understand that I will receive no compensation, should any photographs of my child be used.

_____

Printed name of parent or legal guardian

_____

Signature of parent or legal guardian

_____

Date

6710 N Country Homes Boulevard, Spokane, WA 99208 Phone (509)487-2958 Fax (509)487-3025

Center for Pediatric Therapy

NO SHOES POLICY

(but socks are required)

We have a No Shoes in the treatment areas policy. This is to reduce the amount of dirt for our small children who are crawling on the floors still.

Socks are required. If you did not bring socks, we have socks available for you to use while you are here. We request that you return the socks. We also request that you bring your own socks for future appointments.

You may see some children wearing shoes. We allow some of the children who wear braces for their feet to wear their shoes as the shoes provide the stability to the braces for them to walk.

You may see some of the therapists wearing shoes. Because we are here all day long, some of the therapists have chosen to bring new shoes/never worn outside shoes to wear during therapy for their own comfort and support.

If you have any questions, please feel free to ask.

Thank you