Premier Children's Therapy Center

1000 Holcomb Woods Parkway Suite #422 Roswell, GA 30076

Phone: 770-641-8070 Fax: 770-641-8078

PATIENT DATA FORM

PLEASE PRINT

TODAY'S DATE:

PATIENT INFORMATION

Child's Last Name: First: Middle:	Birth Date:	Age:	Sex: ❑ F ❑ M
Parent/Guardian Name:			
Street address:	City, State Zip Code:		
Home Phone:	Mobile Phone:	Email:	
Physician (s): (If group, please provide practice name and name of primary physician)			
Physician's Address:			
Physician's Phone:	Physician's Fax:		
Specialists:			
School Name and Grade:			
Referred By:			

PRIMARY INSURANCE INFORMATION

(Please provide a photocopy back/front of your insurance card)

Primary Insurance Company:		Type (PPO, POS, HMO):	
Primary Insured Name:	Birth Date:	Address (if different):	Home Phone:
Member Id:	Group:	Employer:	
Insurance Carrier's Mailing Address/Provider Service Phone # (From back of card)			

SECONDARY INSURANCE INFORMATION

(Please provide a photocopy back/front of your insurance card)

Secondary Insurance Company:		Type (PPO, POS, HMO):	
Primary Insured's Name:	Birth date:	Address (if different):	Home Phone:
Member Id:	Group:	Employer:	
Insurance Carrier's Mailing Address/Provider Service Phone # (From back of card)			

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HIPAA PRIVACY PRACTICES

The purpose of this notice is to ensure that you (the patient) or your designated representative are aware of your rights to ensure the privacy of your healthcare information. Premier Children's Therapy Center, Inc. retains the right to update this notice at any time. You may specify your designated contacts.

Child's Name: ____ **Date of Birth ____________________**

1. **Privacy of Patient Information:** We have created a record of the services and treatment received at Premier Children's Therapy Center. The privacy of your child's medical information is important to us and we are committed to protecting it. We are required by law to keep medical information private and notify you of legal rights and privacy practices.
2. **Use and Disclosure of Patient Information:** Your child's therapy information will be used for treatment, payment, and to communicate with other **healthcare professionals** (including your child's pediatrician), payers, state and federal entities, as well as law enforcement agencies in the interest of public safety, court/administrative order.
3. **Access to Medical Information:** You have the right to see and obtain a copy of your child's medical records at any time. If you request a copy of the information, we may charge a fee. Additionally, you may request changes to your health information, if you feel information is incorrect or incomplete. If Premier Children's Therapy Center, Inc. does not agree with your changes, you must be allowed to insert a statement of disagreement into the patient's record. Premier Children's Therapy Center, Inc. is not required to agree with your changes.
4. **Confidentiality of Patient Information:** Premier Children's Therapy Center, Inc. will attempt in all cases to preserve the confidentiality of all oral and written medical information. This includes patient records, written information, and electronic transmission of information to physicians, insurance companies, state and federal entities and law enforcement agencies in the interest of public safety. Premier Children's Therapy, Inc. will not be held responsible in the event of natural disasters, theft or burglary of their physical and electronic property having taken reasonable precaution.
5. **How to file a Complaint**: If you feel your privacy rights have been violated, please submit a complaint in writing to our Privacy Officer. There is no penalty for filing a complaint.
6. **Patient Personal Communication:** Premier Children's Therapy Center may communicate confidential information, *including photos or videos* of delivered services, insurance information, appointment reminders, evaluations, and documentation to designated caregivers below:

PARENTS/GUARDIAN:

Name/Relationship to Child____

Mailing Address ____

Phone ___________________________ Fax____________________ Email ____________________

ADDITIONAL CAREGIVER: (Nanny, Babysitter, Grandparent)

Name/Relationship to Child ___________________________________

Mailing Address ____

Phone ___________________________ Fax____________________ Email ____________________

OTHER PROFESSIONALS/SCHOOLS/SPECIALISTS

Name (or title) and organization ____

Mailing Address ____

Phone ___________________________ Fax___________________ Email _____________________

7. **Premier Children's Therapy Center Contact Information:** You may contact the Practice Administrator at 770-851-9553.

Patient's or Designee's Signature _____________________________________ Date ________________________________

CASE HISTORY FORM

(Please Print)

PATIENT INFORMATION				
Child's Name:	Age:	Grade:	Birth Date:	Sex: ❑ F ❑ M
Person Completing This Form:	Relationship To Child:		Physician Name:	Physician Phone #:

BACKGROUND INFORMATION		
Parent 1 Name:	Parent 1 Occupation:	Parent 1 Email Address:
Relationship To Child:	Cell Phone:	Home Phone:
Parent 2 Name:	Parent 2 Occupation:	Parent 2 Email Address:
Relationship To Child:	Cell Phone:	Home Phone:
Street address:	City, State, Zip Code:	
Referred by:		
Describe your child's home environment: (Please include sibling's names and ages and if living with caregivers (i.e. nanny, joint custody)		
Does anyone in your family have speech, developmental, neurological, or hearing problems? If yes, please explain:		
Describe your concerns regarding your child's development:		
Has there been a traumatic life event that your child has experienced? If yes, please describe:		
Has your child been referred by a professional? (Teacher, Physician, etc.)		
Has your child been given a diagnosis? ❑ Yes ❑ No	What is the diagnosis?	
Does your child receive special services? If yes, please explain:		
Has your child's vision been tested? If yes, by whom and when? Please explain the results of the test.		
Has your child's hearing been tested? If yes, by whom and when? Please explain the results of the test.		
Does your child wear any assistive devices?		

_____Hearing Aids	_____Splints	_____Orthotic Inserts	_____ Augmentive Communication Devices	_____Protective Head Gear

PRENATAL AND BIRTH HISTORY

Length of pregnancy in weeks:		Birth Weight:	
Full Term?	Breech?	One Minute APGAR:	Five Minute APGAR:

Prenatal Care Included:

Were there any complications during the pregnancy or birth? If Yes, please explain:

Type Of Delivery: ❑ Induced ❑ Vaginal ❑ Cesarean ❑ Vacuum Extraction ❑ Forceps

Please explain:

Were there any problems or complications immediately following the birth or during the first few weeks of your infant's life?
❑ Jaundice ❑ Feeding ❑ Swallowing ❑ Hospitalizations ❑ Seizures ❑ Other
Please explain:

How long was the infant's stay in the hospital following birth? _________

Did your child come home from the hospital with you? ❑ Yes ❑ No

Breast Fed? ❑ Yes ❑ No How Long? _____________

Bottle Fed? ❑ Yes ❑ No How Long? _____________

Pacifier? ❑ Yes ❑ No How Long? _____________

DEVELOPMENTAL HISTORY

At what age did the following **developmental milestones** occur?

__________ Held head up	__________Followed objects with eyes	__________ Rolled over from back to stomach
__________ Sat up unsupported	__________Crawled	__________ Stood alone
__________ Walked alone	__________Fed self with spoon	__________ Dressed self
__________ Toilet trained	__________Used fork	

At what age did the following **speech/language milestones** occur?

__________ Babbled or cooed	__________Said first word	__________ Begin to use two- word phrases
__________ Begin to use sentences	__________Follow simple directions	__________ Pointed to objects

How does your child express him/her self? (Please circle one)

Sentences Phrases One or two-words Sounds Gestures Other: __________

How many words are in your child's vocabulary? __________________

Does your child have any feeding/swallowing issues? If yes, please explain:

What types of foods does your child prefer?

What type of food does your child refuse?

Please list any medications or supplements that your child is currently taking:

Does your child have any food allergies or follow a special diet? If yes, please explain:

MEDICAL HISTORY

Check any of the following conditions or surgeries that your child has experienced. Please specify age and condition status for each:

CONDITION	YES	NO	AGE	SURGICAL INTERVENTION	DATE(S)	CHRONIC (C) RESOLVED (R)
Adenoidectomy						
Allergies						
Asthma						
Balance/Falling Problems						
Chicken Pox						
Chronic Colds						
Croup						
Diphtheria						
Dysphasia						
Ear Infections						
Encephalitis						
Epilepsy						
Feeding Mismanagement						
Fractures						
Frenulectomy						
GE Reflux (GERD)						
Head Injuries						
Headaches						
Influenza						
Mastoidectomy						
Measles						
Meningitis						
Mumps						
PE Tube Insertion						
Pneumonia						
Scarlet Fever						
Tonsillectomy						
Tonsillitis						
Typhoid						
Whooping Cough						
Other						

Describe any major accidents, surgeries, or hospitalizations your child has had (i.e., car accidents, falls, crash injuries, etc):

EDUCATIONAL HISTORY

Does your child attend:	______Day Care	______Preschool	______Elem/Mid School	______Other:

Name of School:

Address:

City, State, Zip

Number of days per week in school?

Does your child have a current IEP/IFSP? ❑ Yes ❑ No
If Yes, please provide a copy to your therapist on or before your first visit.

Is your child currently experiencing difficulties at school or daycare? If yes, please describe:

Educational, Psycho/Neuro Psychiatric Assessments:
Has your child ever had a full battery of tests done by a psychologist or psychiatrist?

If so, please name testing professional:

What types of tests were done?

What were the Results?

What is most important to you that we work on with your child?

CURRENT FUNCTIONING

On a scale of 1 to 4 how well does your child function in the following areas? (Circle One) Depending on the age of your child, it may be completely appropriate for them to be dependent in many areas of functioning.

1 = Completely dependent on others. Needs lots of help or cues.

2 = Requires adult assistance for 50% of the tasks or 50% of the time.

3 = Requires very little, but some adult assistance.

4 = Completely independent. No difficulties in this area.

Dressing upper body	1	2	3	4	Not Applicable
Taking off clothing	1	2	3	4	Not Applicable
Putting on shoes/socks	1	2	3	4	Not Applicable
Putting on pants	1	2	3	4	Not Applicable
Eating (breast or bottle)	1	2	3	4	Not Applicable
Eating (soft foods off spoon)	1	2	3	4	Not Applicable
Eating (with fingers)	1	2	3	4	Not Applicable
Eating (with utensils)	1	2	3	4	Not Applicable
Playing with familiar peers	1	2	3	4	Not Applicable
Playing with unfamiliar peers	1	2	3	4	Not Applicable
Handwriting	1	2	3	4	Not Applicable
Frustration tolerance	1	2	3	4	Not Applicable
Sleeping Routine	1	2	3	4	Not Applicable
Grooming (hair)	1	2	3	4	Not Applicable
Grooming (bathing)	1	2	3	4	Not Applicable
Grooming (teeth)	1	2	3	4	Not Applicable
Maintaining attention to tasks	1	2	3	4	Not Applicable
Entertaining self	1	2	3	4	Not Applicable
Hand/eye coordination	1	2	3	4	Not Applicable
Balance	1	2	3	4	Not Applicable
Following verbal directions	1	2	3	4	Not Applicable
Safety Awareness	1	2	3	4	Not Applicable
Cutting with scissors	1	2	3	4	Not Applicable

Please list your child's strengths:	
Please list your child's weaknesses:	
What are your goals for therapy?	
Please let us know your child's favorite things:	
Food:	Snack:
Drink:	Candy:
Toy:	Game:
Activities:	TV Show/Movie:
Other Favorites:	
Please use the rest of this page or attach any additional pages you need to share other information that will help us to understand your child and family:	

Please be sure to include copies of the following documents (if applicable): Having these documents will assist your therapist in complete their assessment and getting a complete picture of your child.

- ❑ Current or most recent IEP/IFSP
- ❑ Prior Speech, Physical or Occupational Therapy Evaluations
- ❑ Prior Psychological/Neurological Evaluations

08-2014

Date Completed: ________________

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OFFICE POLICIES

Please read and initial the information listed below:

Patient Name: ______________________________ DOB: ____________________

PLEASE READ CAREFULLY

_______1) **CANCELLATION/NO SHOW POLICY:** Cancellations must be reported **directly to your therapist (or therapists if your child sees multiple therapists)**. Acceptable communication methods are email or text message. Notification must be at **least 24 hours prior to your scheduled visit**. Cancellations or no shows will be assessed a $50 fee, $75 if the scheduled visit falls during nationally observed holiday weeks. This policy will be strictly enforced. Calls to anyone other than the treating therapist are not acceptable. Please ensure that you have your therapist's contact information! Cancellation fees are NOT covered by insurance. In the event of illness, hospitalization or critical care situation, this fee may be waived at the discretion of the clinic director only.

_______2) **ATTENDANCE POLICY:** Therapy visits are reserved especially for your child and their therapist each week. Regular excused or unexcused absences and tardiness that exceeds 20% of the monthly scheduled visits will result in a forfeiture of that therapy slot.

_______3) **EXTENDED TIME:** Extended time with your therapist, after therapy sessions, cannot be accommodated to allow your therapist to attend to her next patient. Additionally, consultation fees may be assessed for extensive phone, email and/or texting with your therapist.

_______4) **INSURANCE INFORMATION:** Premier is happy to contact your insurance carrier to verify your coverage, deductibles, co-pays, policy limits and pre-certification requirements. **Verification of coverage is NOT a guarantee of payment.** Many plans have coverage exclusions for therapy services that are missed, misunderstood or misinterpreted by insurance representatives. You are ultimately responsible for any and all charges incurred from treatment provided, despite conflicting or inaccurate information received from your carrier during the verification process. We request that you contact your Member Services department to verify the information we provide to you.

_______5) **VISIT LIMITS:** Most insurance plans have a defined visit limit for therapy. Many limits are combined with other therapies and therapy received at other facilities. **Patients are responsible for understanding their policy limits and tracking the number of visits incurred.** If your child has a therapy visit beyond the plans limits, you are responsible for the full cost of that visit.

______________________________	______________________________	______________
Guarantor/Parent Name (Print)	Guarantor/Parent Signature	Date

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CONSENT FOR PAYMENT AND FINANCIAL RESPONSIBILITY

Patient Name: ____DOB: ___________________

________1) **Assignment of Benefits:** Premier Children's Therapy Center, Inc is authorized to bill my insurance carrier for direct reimbursement of therapy services rendered to my child. Benefit payment will be assigned directly to Premier Children's Therapy Center. Premier may release only medical information that is needed to determine the benefits payable for related services. Any remaining amount owed for services that are partially covered or not covered are my responsibility.

________2) **Patient Financial Responsibility:** I will be responsible for the cost of all services. Charges may be the result of deductibles, co-pays, co-insurance and all non-covered procedures or treatment codes regardless of in network or out of network status. Depending on your policy, your insurance company will pay all, part or none of the cost of therapy evaluations and visits. I am ultimately responsible for any and all charges for services received by Premier, regardless of whether my insurance carrier should or should not have paid covered the services.

Patients without covered therapy benefits, out of network coverage high deductibles, can self-pay according to Premier's Billing Process.

________3) **Offsite Therapy:** There is an additional $10 fee for offsite therapy, including homes, day care centers, preschools and elementary schools. Off-site fees are not covered by medical insurance plans.

________4) **Billing Insurance:** With this authorization, Premier will file claims to my carrier on my behalf. If charges billed are not paid timely, Premier will make (2) two attempts to resolve the issues. After (2) two attempts, patients arer responsible to pay the charges and resolve the issue with your insurance company. Premier will be happy to reimburse you once payment has been received from the insurance company.

________5) **Insurance Payments:** If payment from insurance is paid directly to insured for services billed by Premier, the full payment amount received by the insurance carrier must be remitted to Premier either via a reassigned check or direct payment from me.

________6) **Billing Invoices:** Each child's visit is documented by their therapist and reviewed by the clinic director before we submit a claim to your insurance company. Additionally, insurance companies may take 4-6 weeks or more to make payments. After receiving an EOB and/or payment from the carrier, any remaining balance due by patient, will be billed monthly. As a result, you may not receive a billing statement until 6-8+ weeks after a visit. We will give you an estimate of your expected rate per visit during intake. Please be aware of this *estimate* to avoid a surprise when the invoice arrives with multiple dates of service at a time.

________7) **Billing**: Patients will keep a preferred payment method on file with the clinic. Statements will be sent the last week of each month for prior months self-pay charges and services that have been processed by insurance. Patients may call the clinic by the 14th of that month with an alternate payment method. The clinic will charge the patients preferred payment method on or after the 15th for any remaining balances.

________8) **Insurance Changes:** I understand that I am responsible for notifying Premier of any changes with my insurance carrier and/or personal data **prior to the start date of the new coverage**. New coverage may require a referral, precertification or other authorization which may necessitate a period of self-pay or break in therapy services. Additionally, new coverage may be subject to different rates and restrictions and exclusions.

I have read the above and agree to be financially responsible for prompt payment and to timely provide all current insurance information.

______________________________	______________________________	______________
Guarantor/Parent Name (Print)	Guarantor/Parent Signature	Date

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ADVANCED BENEFICIARY NOTICE

PATIENT NAME: ________________________________ DOB: ____________________

This notice applies to all insurance carriers, regardless of network status.

The purpose of this form is to advise you of the fees associated with an Occupational, Physical or Speech Therapy evaluation. It is important for you to know that if your therapist recommends an evaluation for your child, you may have to pay a portion or all of the evaluation cost. Please read this entire notice carefully.

Your insurance company may or may not pay in full for an Occupational, Physical or Speech Therapy evaluation. Many insurance plans do not always consider all health care costs as a covered benefit. Your insurance company follows the coverage rules as defined by your plan documents.

Therapy Evaluations involve multiple components including, but not limited to the following items.

- Review of case history, medical history, prior evaluations and reports
- Consultation with parents, teachers, specialists or other therapists (only with proper consents)
- Administering standardized tests, clinical observations
- Collecting results and documentation
- Entering test data into proprietary software to obtain results
- Review and analyze all collected information and prepare a detailed written report.

I understand that if my child requires a therapy evaluation, I may be responsible for all non-covered and non-allowable charges, co-insurance, co-pays and any amounts applied to my deductible. I understand that my Insurance Company may not cover the entire cost of the evaluation services. If my insurance company denies payment, or partially pays, I agree to be personally and fully responsible for payment.

______________________________ ______________________________ ______________

Guarantor/Parent Name (Print) Guarantor/Parent Signature Date

Premier Children's Therapy Center
1000 Holcomb Woods Parkway, Suite 422, Roswell, GA 30076 Clinic:
770.641.8070 Fax: 770.641.8078

BILLING

- ✓ A preferred payment method, provided below, will be required to remain on-file for all patients.
- ✓ If you prefer to call with this information, you may do so, but it is required before your first visit.
- ✓ Invoices will be sent the last week of each month.
- ✓ Only charges processed by your insurance company or self-pay charges will appear on your invoice.
- ✓ You will have the opportunity to call the office with an alternate payment method between the 1st and 14th of each month. Payments NOT received by the 14th of each month will be charged to your preferred payment method on-file with the clinic.
- ✓ Receipts will be sent to you via US Mail.

CREDIT/DEBIT CARD INFORMATION	
PATIENT NAME(S):	
CARD TYPE: **(VISA, MASTERD, AMERICAN EXPRESS ONLY)**	
NAME ON CARD:	
BILLING ADDRESS:	
CARD NUMBER:	
EXPIRATION DATE:	
SECURITY CODE: 4 Digit –AMEX, 3 Digits- ALL others	
Is this an FSA or HSA Card?	❑ Yes ❑ No

The preferred payment method listed above will be charged on, or after the 15th of each month for the prior month's invoiced, self-pay charges or services already processed by insurance, unless you contact the office with an alternate payment prior to the 14th.

Guarantor/Parent Name (Print) ______ Guarantor/Parent Signature ______ Date ______

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________ D.O.B.: ____________

Allergy to: ______________________

Weight: __________ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: ______________________

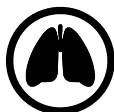
THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

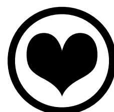
[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

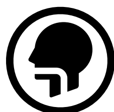
SEVERE SYMPTOMS



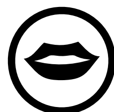
LUNG
Short of breath, wheezing, repetitive cough



HEART
Pale, blue, faint, weak pulse, dizzy

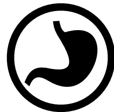


THROAT
Tight, hoarse, trouble breathing/ swallowing

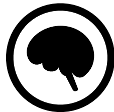


MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness



GUT
Repetitive vomiting, severe diarrhea



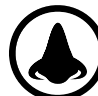
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

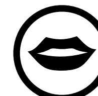
1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE
Itchy/runny nose, sneezing



MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: ______________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if wheezing): ______________________

____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

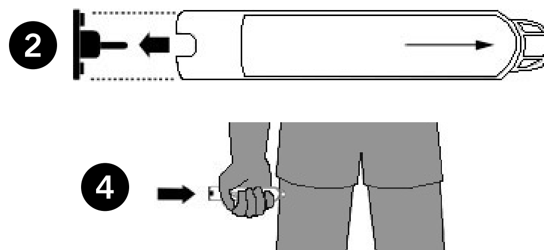
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

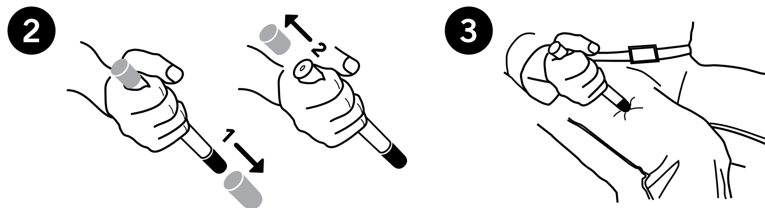
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: ______________

PARENT/GUARDIAN: ______________________ PHONE: ______________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE