Patient History Questionnaire

Patient Name:________________________________ Gender: _____ Age/DOB:____________________
Social Security Number: ____
Parents'/Guardians' Names:____________________________________ Relationship: ______________
Address: ________________________________ City: ________________ State: _____ Zip: __________
Phone: ________________________________ Secondary Phone: _______________________________
Emergency Contact, Number, Relationship: ____
Primary Care Physician:__________________________ City/Phone of PCP:_______________________
Referral Source (if different):___________________ Previous Testing: PT / OT / ST Other: ________
Previous Therapy Services Received from: ____
Most Recent Hearing Screening: ___________________________________ Passed: Yes / NO

INSURANCE INFORMATION:
Insurance #1: ______________________ Policy Number: ___________________________
Insured: __________________________ Relation to Pt: ____________________________
Insured's SSN:______________________ Insured's Date of Birth:______________________
Group Name: ______________________ Group Number: ____________________________
Insured's address, if different from above:
____
____

Insurance #2: _______________________Policy Number: ___________________________
Insured: ___________________________Relation to Pt: ____________________________
Insured's SSN:_______________________ Insured's Date of Birth:_____________________
Group Name: _______________________ Group Number: ____________________________
Insured's address, if different from above:
____
____

Family Information:
Language(s) spoken in the home:____
Names and ages of siblings:____
Names and types of pets:____
Names and relationships of others living in home: ____

Primary Concerns (Please list any information you would like for us to know): _____________________
____
____

Developmental Milestones (At what age did your child begin the following):
Sitting w/o support: ___________ Crawling: ____________ Walking: ___________ Talking: ________
Talking in phrases: __________ Talking in sentences: __________ Hand dominance: R / L / Not Sure

Patient History Questionnaire

Medical History:

Birth: Gestational Age: ______________ Weight: ________________ Delivery: Vaginal / Cesarean

Complications with Pregnancy / Delivery: ____

____

____

Current Diagnosis(es): ____

Current Medications: ____

Hospitalizations (when & why): ____

Surgeries (when & why): ____

Allergies (medicine & food): ____

____

Current Equipment, Orthotics, Accommodations: ____

____

Pertinent Medical History (please circle any that may apply): Autism Apraxia Dysphagia

Asthma	Seasonal Allergies	Tuberculosis	RSV	Pneumonia	Hearing Loss
PE Tubes	Ear Infections	Heart Disease	Anemia	Diabetes	Vision Loss
Seizures	Cerebral Palsy	Cerebral Shunt	Headaches	Broken Bones or Injury	
UTI	Kidney Disease	Frequent Diarrhea	Low Weight	Weight Gain	Skin Problems
Measles	Mumps	Chicken Pox	Flu	Pink Eye	Strep
Depression	Behavior Problems	Night Terrors	Insomnia	Learning Disabilities	

Other: ____

Self Help Skills (Circle all that apply):

Drinks with:	Bottle	Transitional Sippy Cup	Sippy Cup	Straw	Open cup
Eats with:	Fingers	Spoon	Fork		
Eats how:	With help	Independently			
Dresses Independently:		Shoes	Socks	Shirt	Pants
Toilets Self:	Dependent	With Help	Independent		
Toileting Accidents:	NO	Occasionally during the day	Only while sleeping		
Plays Appropriately with:		Toys	Peers	Prefers to Play Independently	
Other (Independently performs):		Brushing / Combing Hair	Tooth Brushing	Washing	

CONSENT TO TREATMENT/CONSENT TO RELEASE INFORMATION

I authorize the staff at Milestones Pediatric Therapy Services, LLC including physical, occupational, and speech therapists as well as any support staff to provide care which they deem beneficial to my child, including services of evaluation and direct care treatment. Furthermore, I understand that Milestones Pediatric Therapy Services, LLC has promised no specific outcomes as to the services provided at this facility.

X___________________________________ ___________________________________
Signature of Parent / Guardian Date

___________________________________ ___________________________________
Relationship Patient Name

X___________________________________ ___________________________________
Witness Date

*patient must be 18 years old or older to sign for their care

---

I authorize the physical, occupational, and speech therapists and support staff of this facility consent to release any or all pertinent medical information to the referring physician and any additional physicians listed below to maintain quality of care. Furthermore, I authorize Milestones Pediatric Therapy Services, LLC to release information to insurance providers to coordinate payment of benefits.

X___________________________________ ___________________________________
Signature of Parent / Guardian Date

___________________________________ ___________________________________
Relationship Patient Name

X___________________________________ ___________________________________
Witness Date

Additional physicians:

Name:_________________________ Name:____________________________
Address:_______________________ Address:__________________________
_______________________ __________________________
Phone:_________________________ Phone:____________________________
Fax:___________________________ Fax:______________________________

Financial Responsibility / Insurance Disclosure

I, ______________________, parent / guardian of ____________________ authorize Milestones Pediatric Therapy Services, LLC, to bill my insurance and receive direct payment from my primary insurance as well as my secondary insurance companies so that Milestones Pediatric Therapy Services, LLC will be reimbursed the therapy services rendered. Furthermore, I understand that I am financially responsible for any fees not paid or covered by my insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance and deductibles which are included as part of my insurance contracts.

It is my responsibility to inquire and understand my insurance policy(s) and communicate with Milestones Pediatric Therapy Services, LLC when coverage changes occur.

By signing this form, I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

X___________________________________ ___________________________________
Signature of Parent / Guardian Date

___________________________________ ___________________________________
Relationship Patient Name

X___________________________________ ___________________________________
Witness Date

*patient must be 18 years old or older to sign for their care

Our staff verifies your insurance benefits prior to the onset of services as a courtesy to you. Although we strive to obtain the most accurate information possible, the quoted benefits from your insurance company are not a guarantee of payment. Should you need the detailed information about your coverage, please contact your insurance company directly.

Any co-pays are due at time of service. Remaining balances (co-insurance, deductibles, and services not covered by your insurance) will be billed to you.

Photography Authorization

I, ______________________________, parent / guardian of ______________________ authorize Milestones Pediatric Therapy Services, LLC to publish photographs taken on the premises of the Milestones Pediatric Therapy Services, LLC clinic of my child, and his/her name and likeness, for use in the Milestones Pediatric Therapy Services, LLC's print, online and video-based marketing materials, as well as other company publications. I understand that protected health information regarding my child will **not** be included in any authorized images and materials.

I hereby release and hold harmless Milestones Pediatric Therapy Services, LLC from any reasonable expectation of privacy or confidentiality for my minor child or myself associated with images obtained for marketing purposes on the premises of the Milestones Pediatric Therapy Services, LLC clinic. Further, I attest that I am the parent or legal guardian of the child listed below and that I have full authority to consent and authorize Milestones Pediatric Therapy Services, LLC to use his/her likeness and name.

I further acknowledge that participation is voluntary and that neither I nor the minor child will receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Milestones Pediatric Therapy Services, LLC publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Milestones Pediatric Therapy Services, LLC, its contractors, its employees and any third parties involved in the creation or publication of company publications, from liability for any claims by me or any third party in connection with the participation of the minor child listed below.

X___________________________________ ___________________________________
Signature of Parent / Guardian Date

___________________________________ ___________________________________
Relationship Patient Name

X___________________________________ ____________________________________
Witness Date

*patient must be 18 years old or older to sign for their care

NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION
Effective Date: December 14, 2015

Background
The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

General Rule
The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices. See 45 CFR 164.520(a).

Milestones Pediatric Therapy Services, LLC is required by law to maintain the privacy and confidentiality of all protected health information. We will do our upmost to safeguard the privacy of all patient/client information provided to Milestones Pediatric Therapy Services, LLC by the client or any third party entities.

How Your PHI will be used:
Protected heath information, or "individually identifiable health information," will be obtained and kept onsite via current documentation systems utilized by Milestones Pediatric Therapy Services, LLC, and online in protected documentation systems in accordance with federal regulation. Protected health information will be used to provide direct care and treatment services onsite, used for payment purposes with authorized insurance companies and their representatives, both indirect and onsite at their request, and will be used for communication of care with other authorized health care providers. Protected health information may also be used for health care operations, not limited but including the following: quality assurance, competency assurance activities, conducting or arranging medical reviews, audits, or legal services, and business management, planning, development, and insurance. Milestones Pediatric Therapy Services, LLC must make reasonable effort to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.

Rights
Individuals have the right to review and obtain a copy of their protected health information in Milestones Pediatric Therapy Services, LLC's "designated record set," the group of records maintained by Milestones Pediatric Therapy Services, LLC, that is used to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems. The rule bars right to access for information compiled for legal proceedings and other circumstances listed. See OCR Privacy Rule Summary pg 12 for further details.

Individuals have the right to request that Milestones Pediatric Therapy Services, LLC amend their protected health information in a designated record set when that information is considered inaccurate or incomplete. If Milestones Pediatric Therapy Services, LLC accepts an amendment request, it must make reasonable efforts to provide the amendment to persons that the individual has identified as needing it and to persons that Milestones Pediatric Therapy Services, LLC knows might rely on the information to the individual's detriment.

Individuals have the right to an accounting of the disclosures of their protected health information by Milestones Pediatric Therapy Services, LLC or their business associates.

Individuals have the right to request that Milestones Pediatric Therapy Services, LLC restrict use or disclosure of protected health information for treatment, payment or health care operations, disclosure to persons involved in the individual's health care or payment for health care, or disclosure to notify family members or others about the individual's general condition, location, or death. Milestones Pediatric Therapy Services, LLC is under no obligation to agree to requests for restrictions.

Individuals have the right to request an alternative means or location for receiving communications of protected health information by means other than those that Milestones Pediatric Therapy Services, LLC typically employs.

For further information regarding details of our Privacy Policy, please contact via e-mail at milestonespedstherapy@gmail.com or via telephone. A complete copy of the HIPAA Privacy Notice is available upon request or at http://www.hhs.gov.

For complaints regarding the Privacy Policy, please visit http://www.hhs.gov to contact the Office for Civil Rights.

Privacy Policy Acknowledgement

I, ___________________________, hereby acknowledge that I have received a copy of and understand Milestones Pediatric Therapy Services, LLC's Notice of Privacy Practices for Protected Health Information, in regards to my child's protected health information. I understand I can request copies of HIPAA regulations at any time.

X____________________________________ ____________________________________
Signature of Parent / Guardian Date

____________________________________ ____________________________________
Relationship Patient Name

X____________________________________ ____________________________________
Witness Date

*patient must be 18 years old or older to sign for their care