Patient History Questionnaire

Patient Name:________________________________ Gender: ______ DOB:________________ Age: ______
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 from PCP):____

Previous Testing: PT OT ST Other: ____
Previous Therapy Services Received from: ____
Most Recent Hearing Screening: ____ Passed: Yes / NO
Glasses? 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/Social History:
Language(s) spoken in the home:____
Names and ages of siblings living in home: ____
____
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): ____________________
____
____

Patient Medical History Questionnaire

Please complete each blank or "none" if no answer applies

Gestational Age at birth (how many weeks): _______________ Birth Weight: _______________

Delivery: Vaginal or Cesarean

Complications with Pregnancy / Delivery: ____

____

____

Current Diagnosis(es): ____

Current Medications: ____

Hospitalizations (when & why): ____

Surgeries (when & why): ____

Allergies (medicine & food):____

____

Current Equipment, Orthotics, Accommodations: ____

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

Pertinent Medical History (please circle any that may apply):						
Seasonal Allergies	Asthma	Anemia	Cerebral Palsy	Autism	Hearing Loss	Broken Bone or Injury
PE Tubes	Pneumonia	UTI	Seizures	Apraxia	Vision Loss	
Ear Infections	RSV	Kidney Disease	Cerebral Shunt	Depression	Skin Problems	Feeding Difficulties
Pink Eye	Tuberculosis	Diabetes	Headaches	Behavior Problems	Measles	
Strep	Dysphagia	Low Weight	Heart Disease	Learning Disabilities	Mumps	Picky Eater
Flu		Weight Gain		Insomnia	Chicken Pox	
Other:						

Self Help Skills (Circle all that apply):					
Drinks With:	Eats With:	Dresses Interpedently:	Toilets Self:	Plays Appropriately with:	Other (independently performs):
Bottle	Fingers	Shoes	Dependent	Toys	Washing
Transitional Sippy Cup	Spoon	Socks	Needs Help	Peers	Tooth Brushing
Sippy Cup	Fork	Shirts	Independently	Prefers to play Independently	Brushing/ Combing Hair
Straw	How:	Pants	Accidents?		
Open Cup	With Help		NO		
	Independently		Occasionally during the day		
			Only while sleeping		

Milestones Pediatric Therapy Services, LLC 2800 S. 2nd Suite B Cabot, AR T: 501-286-6075

Academic History Questionnaire

School Age

What grade is your child in? ________________ What school does your child attend? ________________
Teacher's Name: __________________________ May we contact your teacher? YES or NO
Does your child have any of the following?

Dyslexia Dysgraphia Handwriting Difficulties Reading Difficulties

Difficulty with a particular subject? YES or NO If yes, what subjects? ___________________________

Does your child have a 504/IEP? YES or NO If yes, what is included? __________________________
____

Please provide a copy of your 504 or IEP to our office so that we may better serve you.

Does your child receive PT, OT, or ST services at school? YES or NO If yes, please indicate how much of each discipline. PT _______ min/week OT ________ min/week ST ________ min/week

Does your child leave class time for extra help? YES or NO If so, please describe: _________________
____

Preschool Age (3-5)

Does your child attend a preschool? YES or NO If so, where? _________________________________
Teacher's Name: ____________________________ May we contact your teacher? YES or NO
Does your child receive PT, OT, or ST services through a Co-op? ____________________________________
If yes, please indicate how much of each discipline.
PT ______ min/week OT ______ min/week ST _____ min/week

Does your child have any accommodations in the preschool? YES or NO A 504/IEP? YES or NO
If so, please list accommodations: ____
____

Please provide a copy of your 504 or IEP to our office so that we may better serve you.

Does your child attend a Daycare? YES or NO If so, where? ____________________________________

Birth to Age 3

Does your child attend a Daycare? YES or NO If so, where? ____________________________________

Does your child stay home with a parent or sitter? YES or NO If so, who keeps them? ______________

What is a typical daily routine for your child? ____
____

CONSENT TO TREATMENT
CONSENT TO RELEASE REPORTS TO REFERRING PHYSICIAN
CONSENT TO RELEASE INFORMATION TO INSURANCE BILLING

1. 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.
2. I authorize the staff at Milestones Pediatric Therapy Services, LLC including physical, occupational, and speech therapists, as well as any support staff, to conduct re-evaluations for my child as they deem necessary and reasonable within the scope of their practices and treatment plans. Furthermore, I understand that Milestones Pediatric Therapy Services, LLC has promised no specific outcomes as to the services provided at this facility.
3. 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.
4. I authorize Milestones Pediatric Therapy Services, LLC to release information and medical records to insurance providers to coordinate payment of benefits. I understand that these records may be requested at any time by insurance carries and will be produced for them on my behalf by Milestones Pediatric Therapy Services subsequently without my prior notification.

X___________________________________ ___________________________________
Signature of Parent / Guardian Date

___________________________________ ___________________________________
Relationship Patient Name

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

Please list any additional physicians that you wish our evaluation reports be released to.

Physician Name: Office Location: Telephone:

1. ____
2. ____
3. ____

Milestones Pediatric Therapy Services, LLC 2800 S. 2nd Suite B Cabot, AR T: 501-286-6075

Attendance Policy

Your child's wellbeing, growth, and development is important to us, which means we strive to see maximal potential gains. Consistent care is crucial in helping your child master their goals and gain the most benefit from their therapy services.

We also want to be considerate of our therapists' time and the time of our other clients. Therefore, we have the following policy.

1. We have a 4 hour cancelation policy. We must be notified either by phone call or text message reminders at least four hours before session is scheduled. If no notification is received without advanced notice, the session will be considered a NO SHOW. Only in case of true emergencies will exceptions be considered by office staff/therapists.

2. We have a 15 minute late policy. If you are going to be late for your child's appointment, please call to let the therapist know. We ask that our therapist only wait 15 minutes for a late appointment. If your child is more than 15 minutes late, the session is considered a NO SHOW and the therapist MAY no longer be available.

3. 4 NO SHOWS or 2 NO SHOWS in a row will be grounds for removal from the schedule. **A reinstatement fee of $15.00 is required to resume scheduled time after such occurrences or your child will be placed on the waiting list until another appointment time becomes available.**

4. Sick Policy: To prevent the spread of illness we ask that your child be symptom or fever free for 48 hours before attending a therapy session.

By signing below, I consent to the above attendance policy. I also consent to any charges that may occur as a result of failure to abide by said attendance policy.

X_____________________________________ _____________________________________

Signature of Parent / Guardian Date

_____________________________________ _____________________________________

Relationship Patient Name

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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

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

Privacy Policy Acknowledgement
Notice of Privacy Practices 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

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KEEP FOR YOUR RECORDS

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.

Procedures and Policies on Illnesses and Diseases

The following is a list of guidelines on common illnesses encountered by children. These guidelines were developed to protect and secure a healthy environment for our patients and staff.

- **Covid-19:** If your child is exposed, suspected or has been diagnosed with covid-19, please contact our office at 501-286-6075.
- **Influenza**: If your child is suspected or diagnosed with influenza, please keep your child home for 48 hours after their fever is gone. The fever should be gone for at least 48 hours without the use of a fever-reducing medicine.
- **Fever:** If your child has a temperature of 100 or more, please keep your child home until free of fever for 48 hours without being treated with medication. Please do not give your child Tylenol or Advil to lower their fever and bring them to therapy.
- **Coughing:** If your child's cough is persistent, please keep them home until coughing is less consistent.
- **Vomiting/Diarrhea:** If your child is vomiting or has diarrhea, please keep your child home until they have been symptom free for 48 hours.
- **Strep Throat:** If your child is suspected or has strep throat, please keep your child home until he/she has been taking antibiotics for 24 hours and free of fever for 48 hours.
- **Viral Infections:** If your child is suspected or has been diagnosed with any viral infection please keep your child home for 3 days and until the rash clears and is free of fever for 48 hours.
- **Chicken Pox:** If your child is suspected or has been diagnosed with chicken pox, please keep your child home until all sores have disappeared or are healed.
- **Hands, Foot and Mouth (HDFM):** If your child is suspected or has been diagnosed with HDFM, please keep your child home until ALL symptoms including rash, sores, cough, runny nose, and fever have been gone for 48 hours.
- **Mumps:** If your child is suspected or has been diagnosed with mumps, please keep your child home until the swelling is gone.
- **Measles:** If your child is suspected or has been diagnosed with Measles, please keep your child home until sores have disappeared or healed.
- **Fungus (Ringworm):** If your child is suspected or has been diagnosed with Ringworm, please keep your child home until all lesions are completely healed.
- **Impetigo:** If your child is suspected or has been diagnosed with impetigo, please keep your child home until all sores and blisters are completely healed.
- **Pink Eye:** If your child is suspected or has been diagnosed with pink eye, please keep your child home until they have a doctor's statement stating he/she is not contagious.
- **Scabies:** If your child is suspected or has been diagnosed with scabies, please keep your child home until they have a doctor's statement stating that he/she is not contagious.
- **Head lice/ Nits**: If your child is suspected or has been diagnosed with head lice, please keep your child home until appropriately treated and free of lice/nits.
- **Croup**: If your child is suspected or has been diagnosed with croup, please keep your child home until they are symptom and fever free for 48 hours.
- **Pneumonia:** If your child is suspected or has been diagnosed with pneumonia, please keep your child home until they are symptom and fever free for 48 hours.

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.

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.

1. Any co-pays are due at time of service.
2. Deductibles will be due at time of service.
   You may speak to an office manager if a payment plan is needed
3. Remaining balances (co-insurance and services not covered by your insurance) will be billed to you after insurance has been billed.

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

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 or coverage. Should you need the detailed information about your coverage, please contact your insurance company directly.

Currently my coverage is reported by my insurance company as follows:

1. Co-Pay: ______________________________
2. Deductible: ___________________________ Remaining: _______________________
3. Co-Insurance: __________________________

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

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