Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

PATIENT IDENTIFICATION

Child's Name_____ M___ F___ Date of Birth_____
Home Address_____ Home Phone_____
City/State_____ Zip Code_____

Primary Care Physician_____Phone_____
Address_____
City/State_____ Zip Code_____ Fax_____
Referred By: _____

School Child Attends_____
Address_____ Phone_____
City/State_____ Zip Code_____

FAMILY INFORMATION

Email Address:_____
Father's Name_____**Date-of-Birth**_____
Home Address(if different)_____
Home Phone(if different)_____Cell Phone_____ Work Phone_____

Email Address:_____
Mother's Name_____**Date-of-Birth**_____
Home Address (if different)_____
Home Phone (if different)_____Cell Phone _____Work Phone_____

Legal Guardian (if different)_____ Phone_____
Home Address_____
City/State_____Zip Code_____

INSURANCE INFORMATION

Name of Insured_____ Date of Birth_____
Insurance Co_____ ID# _____ Group #_____
Type of Insurance: PPO_____POS_____HMO____ Other____ Secondary Policy: Yes_____ No_____

EMERGENCY INFORMATION

Please provide the names and telephone numbers of two people who we can contact in case you cannot be reached in an emergency:
Name_____ Phone_____
Name_____ Phone_____

Signature_____ **Date**_____

Family History:

Child lives with (check one):

☐ Birth Parents ☐ Foster Parents ☐ Siblings (ages: ____ ____ ____ ____)
☐ Adoptive Parents ☐ One Parent
☐ Parent & Step-parent ☐ Other: _____

Is there a family history of speech, language, learning or motor issues? (If yes, please check)

- ☐ Speech/Language Difficulties
- ☐ Hearing Impairment/Deafness
- ☐ Learning Difficulties
- ☐ Developmental Difficulties
- ☐ Gross Motor Delay
- ☐ Fine Motor Delay

What are your current concerns? _____
_____
_____
_____

Other Language Exposure:

Is there a language other than English spoken in the home? ☐ Yes ☐ No
If yes, which language?_____Does the child speak this language? ☐ Yes ☐ No
Does the child understand this language? ☐ Yes ☐ No
Which language does the child prefer to speak at home? _____ At school? _____

Birth & Medical History:

Length of pregnancy (weeks) _____
Any complications with pregnancy or delivery? ☐ Yes ☐ No
If yes, please explain:_____
_____
_____

Birth Weight: _____

APGAR Score _____

Multiple births. ☐ Yes ☐ No

Hospitalizations/Surgical History

Date(s): _____

Reason for Hospitalization: _____
_____
_____

Date(s): _____

Reason for Hospitalization: _____
_____
_____

Known Precautions/Allergies (please check)

Medical allergies: ☐ Latex ☐ Other_____

Food Allergies: ☐ Dairy ☐ Gluten ☐ Soy ☐ Nuts ☐ Other

Epi Pen: ☐ Yes ☐ No

Current Medications: (Please List)

_____

_____

_____

Neurological History/Current Concerns ☐ Not Applicable

History of or current neurological deficits? ☐ Yes ☐ No

Please explain: (low muscle tone, seizures etc.)

Neurologist's name and phone number if applicable:

_____

Cardiac History/Current Concerns: ☐ Not Applicable

History of heart problems? ☐ Yes ☐ No

Does your child have CURRENT cardiac issues/needs? ☐ Yes ☐ No

Cardiologist name and phone number if applicable:

_____

Respiratory History/Current Respiratory Concerns ☐ Not Applicable

History of respiratory problems (check all that apply if applicable)

☐ Apnea ☐ Asthma ☐ Pneumonia ☐ Bronchitis ☐ Nasal/Chest Congestion

☐ Malacia bronch ☐ Malacia laryngo ☐ Malacia trachea ☐ BPD ☐ Mouth Breather

☐ Wheezing Any breathing treatments? _____

Have your child's tonsils or adenoids been removed? ☐ Yes ☐ No

Please specify surgery date and if one or both were removed or shaved:

How many colds each year?

How many upper respiratory infections?

Does your child have current respiratory problems ☐ Yes ☐ No

Current ENT doctor name and phone: _____

Current Pulmonary doctor name and phone: _____

Gastrointestinal History/Current GI Concerns ☐ Not Applicable

History of GI deficits? ☐ Yes ☐ No

If yes, please check all that apply:

☐ Altered Peristalsis	☐ Bowel Obstruction	☐ Crohn's Disease	☐ Chronic Diarrhea
☐ Constipation	☐ Dehydration	☐ Diabetes	☐ Esophagitis (Eosinophilic)
☐ Failure to Thrive	☐ Slow Gastric Emptying	☐ Short Bowel	☐ Vomiting

History of GI surgeries? ☐ Yes ☐ No

Did your child receive any alternative feeds? ☐ Yes ☐ No
If yes, **please circle** (G tube, J tube, NG tube, PEG tube)

Has your child had any of the following tests completed?
Please circle Video-fluoroscopic Swallowing Evaluation, FEES study, Upper GI, Ph Probe
Results of testing:

Current GI Status: ☐ No problems ☐ Current Issue ☐ Regular follow up with Gastroenterologist

Gastroenterologist name and phone number if applicable: _____

Do you or your doctor have any concerns about recent weight gain or loss? ☐ Yes ☐ No
If yes, please explain

Has your child had a nutritional consult? ☐ Yes ☐ No

If yes, please state nutritionists name and phone: _____

Cranial - Facial Concerns
History of a helmet/cranial orthotic use? ☐ Yes ☐ No
History of lip or palate defects? ☐ Yes ☐ No
Sinus Infections? ☐ Yes ☐ No Diagnosed Genetic Syndrome? ☐ Yes ☐ No
Do you ever notice food coming out of the nose? ☐ Yes ☐ No
Dental Concerns? ☐ Yes ☐ No
Please circle (Narrow Palate, High Palate, Crowding of Teeth, Tongue Tie, Lip Tie)

Hearing History/ Current Hearing Concerns ☐ Yes ☐ No
Please list:

How many ear infections has your child had? _____

Does your child have ear tubes placed? ☐ Yes ☐ No

Has your child had chronic ear infections? ☐ Yes ☐ No

Has your child had any of the following (please check)

☐ Adenoidectomy	☐ Frequent Colds	☐ High Fevers	☐ Tonsillectomy
☐ Allergies	☐ Frequent Ear Infections	☐ Head injury	☐ Tonsillitis
☐ Breathing Difficulties	☐ Ear (PE) Tubes	☐ Sleeping Difficulty	☐ Vision Problems
☐ Feeding Issues	☐ Reflux	☐ Thumb/Finger Sucking	☐ Other

If you checked any, please provide details/dates:

Other serious illness/injury? ☐ Yes ☐ No
Please list:

Date of last hearing screening:_____Results: ☐ Typical ☐ Atypical
Date of last vision screening: _____ Results: ☐ Typical ☐ Atypical

Hospitalizations (dates and procedure):

Developmental Motor History:
Please check all developmental milestones that your child has achieved and indicate age acquired, if known. (Some may not yet be applicable.)

☐ Rolling _____
☐ Sitting Independently _____
☐ Crawling _____
☐ Independent Standing _____
☐ Walking _____
☐ Jumping _____
☐ Uses hands together at the center of the body _____
☐ Grasped crayon/pencil _____
☐ Uses finger and thumb to pick up items _____
☐ Printing name ____
☐ Right or left hand dominant _____

Self Help:
Has your child experienced feeding/eating difficulties (biting, swallowing, chewing)? ☐ Yes ☐ No
If yes, please explain:

Early feeding patterns. ☐ Breast feeding ☐ Bottle feeding
Does your child eat by self using utensils? ☐ Yes ☐ No
Does your child drool? ☐ Yes ☐ No
Does your child mouth non-food items? ☐ Yes ☐ No

Does your child have food preferences/aversions? □ Yes □ No
If yes, please explain:

Does your child avoid eating or touching textures. □ Yes □ No
Tolerates bathing □ Yes □ No
Helps with dressing □ Yes □ No
Toilet Trained □ Yes □ No
Co-sleeping □ Yes □ No
Does our child still nap? □ Yes □ No
Can your child fall asleep and stay asleep through the night, on their own? □ Yes □ No

Speech & Language Development:
How does your child prefer to communicate? (Please check)
□ Gesture □ Words □ Push/Pull □ Pointing □ Crying
Age first words were produced. _____
Number of words in a typical sentence? _____
Is your child's speech difficult to understand? □ Yes □ No
Does your child identify objects? □ Yes □ No
Does he/she ask questions? □ Yes □ No
Follow directions? □ Yes □ No
Understands what you are saying? □ Yes □ No
Responds correctly to yes/no questions? □ Yes □ No
Is your child aware of, or frustrated by, any speech/language difficulties? □ Yes □ No

School History:
Has your child ever repeated a grade? □ Yes □ No If so, what grade?_____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty with a particular subject? □ Yes □ No
If yes, what subject? _____

Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)?
□ Yes □ No If yes, please explain:

Favorite Activities:
Please list your child's favorite activities, hobbies, toys, games etc.:

Please indicate any other information that may be helpful to give us more information about your child:

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

I hereby give permission for my child, _____, to be treated by Arlington Pediatric Therapy Management Services, Ltd. for therapy services. Therapy services have been explained to me, I understand this treatment and explanation and approve of said treatment.

The policy of this clinic is that payment is due at the time of service. Insured patients are expected to take care of their fees as services are rendered. Your assistance in complying with our payment policies will help control our overhead expenses, thereby keeping fees reasonable.

Patients who carry health care insurance should remember that professional services are rendered to and charged to the patient and not to the insurance company. When we file a claim for you, you will receive a statement each month if your account has a balance due. Your insurance carrier may pay less than the actual bill for services. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed benefit/claim. You are responsible for payment of your account within the limits of our office credit policy; copays are due at time of service, deductible and coinsurance are due within 30 days of statement.

If, for any reason, your account is referred to our collection agency, you will be responsible for all collection costs, court costs and reasonable attorney's fees.

If a carrier should deny coverage for physical, occupational, speech or aquatic therapy, you will be responsible for the account. Failure to keep your account current may result in APTMS being unable to provide additional services. Credit may be extended upon request in cases of sizable balances. We accept cash, checks, Visa, MasterCard, and Discover.

A $25.00 charge will be added to the account for each returned check.

If your insurance card has not been issued to you by the time of your visit, you will be treated as a self-paying patient; payment will thus be expected at the time of the visit and the claim will be submitted for you when we receive a card. Please be sure to notify our office immediately should you change medical insurance carrier, home address or telephone number.

As a client of APTMS, Ltd., your signature is required below as acceptance of our office policies and as acknowledgment that you have been advised of these policies. In addition, your signature will service as authorization to release medical account information to your insurance carrier(s) to process your medical claims, as needed.

Your signature also denotes that you recognize and accept full responsibility for all professional services rendered and further authorizes the insurance carrier(s) to pay benefits directly to this clinic if a balance is due.

It is our policy that the parent or guardian accompanying the child to the clinic will be responsible for full payment of the bill. Thank you for your understanding. Please let us know if you have any questions or concerns.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

NOTICE and ACKNOWLEDGEMENT

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

Printed Patient Name:_____

Patient or Personal Representative

Signature:_____Date:_____

If Personal Representative's signature appears above, please describe Personal

Representative's relationship to the patient:_____.

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

I, _____, hereby give my consent to
(Name of Authorized Agent)
Arlington Pediatric Therapy Management Services, Ltd. to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in the patient record of _____.
(*Patient's Name)*
I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Arlington Pediatric Therapy Management Services, Ltd. I also understand that I will not be able to revoke this consent in cases where Arlington Pediatric Therapy Management Services, Ltd. has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the Arlington Pediatric Therapy Management Services, LTD's office.

Signed: _____Date: _____

If you are not the patient, please specify your relationship to the patient_____.

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

NOTICE OF EARLY INTERVENTION PROGRAM

I have been informed by Arlington Pediatric Therapy Management Services that there is a federal and state Early Intervention program available for children under 36 months of age that may help pay for therapeutic services.

Child's Name	Date of Birth
Parent / Guardian Signature	Date

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

EMERGENCY TREATMENT RELEASE

TO WHOM IT MAY CONCERN:

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. This release form is completed and signed of my own free will, with the purpose of authorizing medical treatment under emergency circumstances.

Name of Minor:_____DOB:_____

Home Phone #:_____Cell Phone #:_____

Home Address:_____

Please specify any medical condition which would be important to inform medical personnel in an emergency (i.e., allergies, blood type, heart condition, diabetes, seizure disorder, medications, etc.)

_____

_____

_____

_____

Please list in order of preference the individuals APTMS should contact in case of an emergency.

1) _____Phone:_____
2) _____Phone:_____
3) _____Phone:_____

Date or dates when release is intended:_____

Parent/Guardian Signature:_____

Date:_____

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

Credit Card Authorization

This is not an online form. Please print the form, fill it out and bring it to your next appointment.

Child's/Patient's Name: _____

Monthly Credit Card Authorization

By signing below, you confirm that you fully understand that health insurance policies and reimbursement issues are between you and your health insurance company. All services rendered to your child are charged directly to your insurance however, you are responsible for the monetary portion the insurance company denies or applies toward your deductible, co-insurance and/or copay. You are also responsible for any bill that is denied, for insurance policies that have been changed and not updated with our office.

The undersigned authorizes Arlington Pediatric Therapy to charge their current balance to their credit card for payment of speech/physical/occupational therapy services and/or associated expenses.

Type of Card: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other: _____

Name on Card: _____

Phone: _____ Email: _____

Card Number: _____ Exp. Date: _____ CVC: _____

Billing Address for this credit card (Street/City/State/Zip):

_____

_____

- We ask for 24 hours notice if you find you cannot make your appointment. Last minute cancellations (i.e. less then twenty-four hours before the designated appointment) and/or no calls, no shows will be billed for the treatment session missed and the invoice will reflect that information appropriately. This session will be billed directly to you. We will never bill an insurance company for a missed treatment session.
- This information must match the card, or it will not process. We request that you notify our office as soon as possible if any of this information changes. This agreement will remain in effect, and your card may be charged monthly, until this agreement is cancelled in writing.
- I have completed this form truthfully and to the best of my knowledge.
- I am bound by the Practice's policies.
- I am bound to indemnify the Practice and voluntarily assume all risk.
- Arlington Pediatric Therapy will charge my credit card, as described as above. I further affirm that I am authorized to use this credit card and will not dispute any charge for services rendered.

_____ _____

Signature Date

Thank you for reviewing our policies.
We look forward to answering any questions that you might have during your first visit!

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

Dear Family of_____,

Do you or your child receive SSI (Supplemental Security Income)benefits?
_____Yes_____No

Are you or your child eligible for Medicare benefits?
_____Yes _____No

If no, I certify that _____is not a Medicare beneficiary
(Child/Client's Name)

and if I /he /she becomes such I will notify you.

_____ _____
Signature Relationship to APT client

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

LATE PICK-UP POLICY

In an effort to ensure your child's treatment session is efficient and timely we encourage families to be ready to pick their child up from their therapist 5 minutes before the end of their scheduled treatment session. Families late for picking up their child will be charged $5 per 5 minutes or less and $5 for each increment of 5 minutes after. If this happens more than twice, you will be required to stay in the building during future therapy sessions.

Office staff is unable to complete their own responsibilities if they are watching your child and therapist are unable to supervise your child when their next client arrives. Your timeliness ensures the safety of all of our clients.

Clients receiving therapy during times when the office staff is not present are strongly encouraged to stay on-site during their child's therapy session.

Thank you for your cooperation.

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

EXTENDED LEAVE POLICY

In an effort to provide effective and efficient treatment to all of our clients, it is the policy of Arlington Pediatric Therapy, that clients taking an extended leave, exceeding three consecutive weeks, notify their therapist immediately. The client can pre-pay the self-payer rate each week to hold their spot or the spot will be opened up for another client. If a client does not notify the therapist and three consecutive weeks are missed the session time will be immediately rescheduled to another client. The self-payer rate for a 45 minute session is $82.50 and $110.00 for a 60 minute session. If your session is rescheduled please contact the front office if you would like to initiate therapy once again. We cannot promise that the same time, day or therapist will be available. Thank you for your cooperation.

Arlington Pediatric Therapy

3105 North Wilke Road Suite H
Arlington Heights, Illinois 60004
(P) 847.255.8690 (F) 847.255.2260

Arlington Rehabilitation for
Sports & Orthopedic Injuries
A Division of APT

CANCELLATION POLICY

If for any reason your child will be unable to make their scheduled appointment time, 24 hour notice must be given in order to avoid being charged in full for the session. (Please note we **CANNOT** bill insurance for a missed appointment, so responsibility of the full payment is on the client.) We understand that sudden illnesses or emergencies arise, please call us as soon as you know your child will be unable to make their session due to illness. Missing a session without any prior notification (no show) for any reason will be billed to the client in full. We ask that no more than three (3) missed appointments occur every quarter throughout the year. The quarters will be as follows:

January-March
April-June
July-September
October-December

If three (3) or more missed appointments occur in a given quarter, we reserve the right to schedule another family into that time slot. Sessions begin promptly at the agreed time. If the child is late for the session, the session will still finish at the scheduled time.

This policy is in place out of respect for our therapists and clients. By giving last minute notice or no notice, it prevents someone else from being able to schedule into that time slot.

We appreciate your understanding and efforts in upholding our Cancellation Policy.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Arlington Pediatric Therapy Services, Ltd. As described above.

Thank You,
Arlington Pediatric Therapy Services, Ltd.

_____ _____

Parent/Guardian (Print) Child/Client's Name (Print)

_____ _____

Parent/Guardian (Signature) Date