Pediatric Patient History

Patient: _____ DOB: _____

Mother's Pregnancy/Delivery History
Pregnancy Complications: ☐ yes ☐ no
If yes, list: _____
Length of Pregnancy: _____ Delivery Complications: ☐ yes ☐ no, list:
_____
_____

Complications immediately following birth: ☐ yes ☐ no, list: _____
_____

Developmental Milestones Please list the age that your child accomplished each of the following:

☐ Developmental milestones were met on time; no delays.

Sat unassisted _____ Crawled _____ Walked unassisted _____

What are your concerns for you child? _____

_____

What are your goals for therapy? _____

_____

Around what age did you become concerned? _____

Previous/Current Therapy: _____

Daycare/Preschool/School: _____

Physician: _____

Specialists/ other therapies: _____

Current Medications: _____

Date of injury: _____ **How did the injury occur?** _____

Have you been hospitalized for the present problem? ☐ **yes** ☐ **no** **If yes, dates:** _____

Have you undergone surgery for the problem? ☐ **yes** ☐ **no** **If yes, dates:** _____

Have you had previous treatments for the problem? ☐ **yes** ☐ **no** **If yes, specify Types/Results of treatment:** _____

Specialized Equipment

❑Splints ❑Walker ❑Crutches ❑Wheelchair ❑Orthotics
❑Other_____

Age achieved/further information

Caught a thrown object:_____ Crawled on hands and knees:_____

Hold head up:_____ Pedaled a bicycle:_____

Pedaled a tricycle:_____ Ran:_____

Rolled over:_____ Stood alone:_____

Threw objects actively:_____ Unsupported sitting:_____

Walking without holding on:_____ Does your child "w" sit?_____

Cut paper with scissors?_____ Labeled colors?_____

Scribbled with a crayon?_____

Self-Care Skills: Please note that this information is only used for treatment planning and to track progress. Your child may not be able to perform some of the tasks due to age or development level. Please answer as accurately as possible for your child's behavior *most of the time*.

Action	Dependent (Caregiver does majority or all of the task for the child.)	Partial Assist (child does majority of task but requires minimal help)	Verbal Assist (Child does majority of task but requires verbal guidance)	Independent (Child performs 100% of the task)	Unable /Refuses
Shirt on	❍	❍	❍	❍	❍
Shirt off	❍	❍	❍	❍	❍
Pants on	❍	❍	❍	❍	❍
Pants off	❍	❍	❍	❍	❍
Shoes on	❍	❍	❍	❍	❍
Shoes off	❍	❍	❍	❍	❍
Jacket on	❍	❍	❍	❍	❍
Jacket off	❍	❍	❍	❍	❍
Tie shoes	❍	❍	❍	❍	❍
Untie shoes	❍	❍	❍	❍	❍
zips	❍	❍	❍	❍	❍
Buttons	❍	❍	❍	❍	❍
Unbutton	❍	❍	❍	❍	❍

Self-Care Skills continued:

Washes hands	❍	❍	❍	❍	❍
Eats a variety of foods	❍	❍	❍	❍	❍
Opens containers	❍	❍	❍	❍	❍
Closes containers	❍	❍	❍	❍	❍
Brushes teeth	❍	❍	❍	❍	❍

Educational History: ❑No school ❑Preschool ❑Elementary school ❑Homeschooled ❑Early Intervention School

Name of School:_____

Informant: _____

Relationship to Patient: _____

Please use the back of this page to report any further significant information.

General Consent Form

Consent for Treatment: I consent to evaluation and treatment as determined by Raise The Bar Therapy Services. It is understood that the patient is participating in evaluations and therapy by will and may choose to discontinue services at any time. The withdrawal of consent cannot be applied to action previously taken by Raise The Bar Therapy Services or to any actions in process. The provider may discharge the patient based on guidelines defined in Policies and Procedures. I am aware that Raise The Bar Therapy Services is offering no guarantees as to the results and outcomes of therapy. This consent will be effective from the date signed until patient is released as a patient of Pender Pediatric Therapy.

Provider Responsibility

- Raise The Bar Therapy Services will keep accurate and complete records of all patient encounters.
- Raise The Bar Therapy Services will not evaluate or treat any patient without parent consent and physician order (if applicable per insurance).
- Raise The Bar Therapy Services will provide costs to the patient prior to encounter, to the best of our ability.
- Raise The Bar Therapy Services is committed to protecting to your personal information and will use it within the scope outlined in *Notices of Privacy Practice.*

Patient Responsibility (Please initial)

- The patient is responsible for providing accurate demographic and insurance information and medical history.
- The patient is responsible for complying with all policies and procedures associated with Raise The Bar Therapy Services.

_____I have received a copy of *Notices of Privacy Practice* and *Policies and Procedures*.

_____I give permission for Raise The Bar Therapy Services to bill my insurance company for services rendered.

_____I understand that I am responsible for all charges not paid by my insurance company.

_____I understand that I am responsible for applicable co-pays or session costs at the time of service. Billed services should be paid within 30 days.

_____I understand that if a check is returned from my banking institution I will be charged a $25.00 return check fee. After 2 returned checks, Raise The Bar Therapy Services will no longer accept check payments.

_____I have read, understand, and agree with all statements on this consent form.

_____I am the patient or am authorized to act on behalf of the patient to sign this form.

_____ _____

Patient's Printed Name **Date**

_____ _____

Patient/Guardian Signature **Date**

PEDIATRIC HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I, _____, parent or legal guardian of _____, give authorization for release of my child's protected health information (PHI) to **Raise The Bar Therapy Services, LLC** regarding my child's billing, condition, treatment and prognosis to the following individual(s):

- Name _____ Relationship _____
- Name _____ Relationship _____
- Name _____ Relationship _____

I understand that I have the right to revoke this authorization verbally and/or in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that information used or disclosed pursuant to this authorization my be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Parent/Legal Guardian_____

Date _____

Patient Information

Child's Full Name: _____DOB:_____Sex:M/F

Address: _____City:_____State:_____Zip:_____

Parent/Guardian Information:

Father's Full Name:_____DOB:_____

Mother's Full Name: _____DOB:_____

Guardian's Full Name: _____DOB:_____

Address:_____

Home Phone:_____Cell Phone:_____

Email:_____

Custody Status: ❑ Joint ❑ Mother (Documentation Required)
❑ Father (Documentation Required)

❑Other: _____
(Documentation Required)

Primary Care Provider: _____ Phone Number: _____

Primary Insurance (Card Required)

Insurance Company:_____

ID:_____

Policy Holder:_____DOB:_____

Relationship to Patient: ❑Self ❑Parent ❑Other

Secondary Insurance (Card Required)

Insurance Company:_____

ID:_____

Policy Holder:_____DOB:_____

Relationship to Patient: ❑Self ❑Parent ❑Other

Parent/Guardian Signature: _____

Date:_____

FOR OFFICE USE ONLY

Documentation provided by: _____

Documentation: _____

Documentation received by:_____

Date: _____

Policies and Procedures

Therapy Guidelines: Prior to starting treatment, an order from the physician must be received by RTBTS and the patient must participate in an evaluation. If the patient has received an evaluation from a different provider within the past year, a new evaluation may be bypassed with a written report from the previous provider and summary of progress at discharge. Going forward, a re-evaluation will be conducted yearly (or as mandated by insurance) or as needed for progress. An evaluation report will be written and sent to the physician and/or insurance company as requested. The patient may request a copy of the evaluation report.

Once the evaluation is complete, a Plan of Care (POC) will be set. The POC will include goals, interventions, and estimated length for POC to be addressed. A copy of the POC will be sent to the physician and/or insurance company as requested. The POC will be used to track progress. Progress reports will be completed at the end of each POC and will help guide the next POC. A discharge summary will be completed at the end of therapy, and may also be provided to the physician and/or insurance. The patient may request a copy of POCs, progress summaries, and discharge reports.

Physician orders must be kept current, as mandated by insurance. RTBTS will initiate a new order for the patient, but any lapse may result in therapy being put on hold until necessary documents are received.

Payment Policy: Any co-pays or session costs are due at the time of service. Raise The Bar Therapy Services will do their best to obtain co-payments, co-insurance, or any other patient responsibility prior to the session. Please be aware that the patient's responsibility will ultimately be determined by the insurance company. RTBTS will always attempt to receive payment from insurance companies, but any costs not covered are the patient's responsibility. Balances will be billed on a monthly basis, unless otherwise arranged.

For families that are private pay or bill private insurance, a credit card **must** be kept on file. Credit cards will not be automatically charged at the time of service, unless authorized to do so (see Authorization for Credit Card Use form). Balances are considered late after 30 days and a 10% fee will be added on. Another 10% late fee will be added every 30 days to the balance of the account. Outstanding balances after 60 days will be charged to the card of file. If the family opts out of having a card on file, the full session cost is due at time of service. Patient is subject to termination of services after 60 days with an unpaid balance. Payment plans are available upon request. Unpaid balances will be turned over to collections if arrangements are not made. A self-pay discount is available, meaning no insurance is filled on the patient's behalf. An invoice will be provided monthly for all session costs for your records. **Initial** _____

Attendance policy: Success in therapy depends on consistent intervention. It is important for the patient to attend all scheduled sessions. It is understood that circumstances will arise that interfere with scheduled sessions. Cancellations should be made one business day prior to the scheduled appointment when possible. Cancelled sessions by the clinician will be offered a make-up session to be scheduled within one month of the missed session, to the best of our ability. Patients have the option to accept or decline make-up sessions. Cancelled sessions by the patient *may* be offered a make-up based on availability of the clinician. Excessive cancellations may result in services being decreased or terminated, as determined by the clinician. Insurance policies dictate a minimum number of minutes per session in order for that session to be billed. If your child arrives more than 15 minutes late, they may not be able to be seen for their session and will be considered a "no show".

A "no-show" is considered to take place when a patient does not arrive for a scheduled session without making contact at least 6 hours prior to the session. No-shows will not be offered a make-up session. If being seen in the home, a no-show will be recorded if the clinician arrives and the patient is not home, if the parent/guardian is not home, or any other reason that prevents the session from being completed. Two consecutive no-shows will result in discharge from therapy. If the patient is being seen outside of the clinic (home, child care facility), it is the responsibility of the parent/guardian to communicate with the front office and/or clinician if the patient will not be available on scheduled therapy days due to absence, outing, special activity, etc. **Initial** _____

18676 US Highway 17N, Hampstead, NC 28443
Phone – 910-821-1700; Fax – 910-319-9105

Release of Information

I hereby authorize the exchange of information indicated below concerning:

_____ _____
Patient's Name DOB

_____ Occupational Therapy Evaluation Reports and Treatment Notes

_____ Physical Therapy Evaluation Reports and Treatment Notes

_____ Health/Medical Records or Reports

_____ Verbal Exchange of Information between Professionals

_____ Other _____

The exchange of information is granted to occur between Raise The Bar Therapy Services and:

_____

_____

_____

I understand that I may revoke this consent at any time. Information already exchanged based on this signed consent may not be revoked.

This consent expires one year from the date is signed.

_____ _____
Signature Date

_____
Relationship to patient

Health Insurance Benefit Information

Patient's Responsibility:

- To know your insurance policy.
  - You should be aware of your benefit coverage including:
    - covered and non-covered benefits, and
    - cost share information such as deductibles, co-insurance, and co-pays.
  - If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- Any non-covered services are your responsibility.
- To pay your co-pay at the time of service.
- To pay any deductible and co-insurance amounts not covered by your supplemental insurance.
- To review the Explanation of Benefits (EOBs) received from the insurance company and if claim was not covered, to contact the insurance company to inquire reason.

Raise the Bar Therapy Services will:

- As a courtesy, contact your insurance company to confirm:
  - Participation with your plan
  - Effective/end date, if coverage is currently active and therapies covered.
  - If there are a maximum number of visits allowed.
  - If there is a co-pay, deductible and/or co-insurance.

The insurance company may not give us the correct information so it will be up to you to confirm what they have told us is correct.

When a payment is collected at the time of check-in, it is applied to that date of service. When it is applied to your account by the billing service, it will be applied to the oldest processed claim which means they dates may not match when we provide a statement and patient payment record. It will go toward your deductible and/or out of pocket for the year paid even if it is applied to a claim from the previous year.

RTBTS has the responsibility to provide you with the best possible care. When you schedule your appointment, you are committing to remaining compliant with the Plan of Care determined by the doctor and therapist to assist in your recovery. We at RTBTS do understand that sometimes things happen, and you might not be able to attend appointments as anticipated. When this happens, please contact our office as soon as possible when cancellation or re-scheduling is required. The therapists are scheduled to be here to provide care to their patients and must be paid by RTB even if the patient a no-show.

Patients who no-show for a scheduled appointment without a 24-hour notice will incur a charge of $25. After the third (3rd) no show, you will no longer be a patient of Raise the Bar Therapy Service, treatment plan will be terminated, and the referring physician's office notified of such.

_____ _____

Printed Name Date

_____ _____

Signature Relationship to Patient

RAISE THE BAR
THERAPY SERVICES
18676 Highway 17
Hampstead, NC 28443
Ph: 910-821-1700

CREDIT CARD AUTHORIZATION

- **NO SHOW/LATE CANCELLATION FEES**
- **INSURANCE COPAYS & DEDUCTIBLES**
- **THERAPY FEES**

In order to provide you and other patients of Raise the Bar Therapy Services the best possible care, a minimum of 24 hours' notice is required to cancel or reschedule your appointments.

I, _____, understand the importance of notifying Raise The Bar Therapy Services **at least 24 hours** prior to my (or my child) scheduled appointment that I am not able to keep the appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $25. I understand that I will be charged a No-Show fee of $25 for failing to call and failing to show for my scheduled appointment.

As per this agreement, the credit card on file will also be used for my remaining portion (co-payment, deductibles, and fees) unless I notify the administrator of a change in credit card status (i.e. cash payment).

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when services rendered by Raise The Bar Therapy Services have ended, this form shall be shredded once I am terminated from treatment.

I am requesting/authorizing that this card be used for payment of services (co-pay, deductibles & fees):

____ Yes ____ No

Name on card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ Code: _____

Street Address: _____ Zip Code: _____

Email address for receipt: _____

Patient Name (printed): _____

Patient (or Parent/Guardian)/Card Holder Signature:

_____ Date: _____