EMPOWER
PEDIATRIC THERAPY

# New Patient Information

Child's full name: _____Date of Birth: _____ Age: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Home phone: _____ Cell #:_____ Work #:_____

Email: _____

How did you hear of us? _____

**Doctor Information:**

Physician/Pediatrician (Name and Facility): _____

Physician Phone Number: _____ Physician Fax Number: _____

**Insurance Information:**

** **Please list insurance information for which the patient is a beneficiary, if you want Empower Pediatric Therapy to file the claim.** **

Policy Holder's Name: _____ DOB: _____

Insurance Company Name and Address: _____

Phone: _____ ID# _____ Group# _____


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# Patient Needs Assessment

Child's Name: _____ Date of Birth: _____

**Birth History**

Child was born: _____ full-term or _____ premature; if premature, how many weeks? _____
Delivery: _____ vaginal _____ with forceps _____ C- section
Were there any complications? _____
Was your child placed in the NICU? _____ If so, how long? _____
Please describe any other medical problems or complications at birth.

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**Development History**

Please indicate at what age your child achieved the following milestones:

*Mark N/A for those which your child has not yet achieved.

Rolled over_____ Pulled to stand _____

Babbled_____ Used Spoon _____

Sat alone_____ Stood alone _____

Said first word_____ Toilet Trained _____

Crawled _____ Walked alone _____

Drank from a cup _____ Dressed Self _____

Comments: _____

**Medical History**

Current diagnosis: _____
Hospitalizations: _____ No _____ Yes
If yes, please describe:
_____
Surgeries: _____ No _____ Yes; If yes, please list _____
_____
Has your child's vision been evaluated? _____No _____Yes; If yes, when and what were the results
_____
Has your child's hearing been evaluated? _____No _____Yes; If yes when and what were the results
_____


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Previous psychological evaluation? _____ No _____ Yes
If yes, please describe
_____
Current Physician(s): _____
Medications: _____
Special equipment your child uses: Splints___ Braces ____ Adaptive Utensils___ Other _____
Any feeding problems or nutritional concerns? _____
Allergies:
_____
Medical Precautions:
_____

**Caregiver Concerns**
What are your main concerns about your child?
_____
_____
What are your child's strengths?
_____
_____
Has your child received occupational therapy, physical therapy, or speech therapy before? Y / N
If yes, please indicate which services and for how long: _____

**Educational Information**
School/Educational Program Currently attending: _____
Present grade level: _____
Special services received in school: _____ OT _____ PT _____ Speech
Does your child receive any of the following?
Special Education_____ Behavior Intervention _____ Other Special service_____
Does your child's teacher have concerns with your child's development in any of the following areas?
Motor Skills ___ Social abilities ___ Self-help skills ___ learning abilities ___
Comments: _____

**Social/Emotional Development**
Does your child interact well with others? ___ Yes ___ No
Does your child have any trouble making friends? ___ Yes ___ No
Fears, Coping behaviors: _____
Does your child have difficulty calming himself/herself when upset? ___Yes ___ No
Additional comments: _____


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**Behavior**

Please check any of the following that apply to your child:

_____ Cries often

_____Dislikes hair brushing

_____Frequent Temper tantrums

_____Dislikes tooth brushing

_____Anxious

_____Avoids touch from others

_____Trouble following directions

_____Dislikes playground equipment

_____Trouble with change in routine

_____Seems to be "on the go"

_____Clumsy

_____Rocks self

_____Weak muscles

_____Sensitive to light

_____Picky eater

_____Sensitive to sound

_____Mouths objects

_____Poor attention span

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Signature: _____ Date: _____



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# Attendance Policy

**Scheduled Appointments:**

- Please arrive for each appointment in time to check in and begin therapy at the scheduled time.
- A late fee of $15 may be assessed if you are more than 15minutes late for your appointment.
- We recommend that you be involved in your child's treatment session. If you do wish to leave, please return 10 minutes prior to the session being completed to enable the therapist to discuss your child's progress.

**Cancelations:**

- If you must cancel an appointment due to an illness or emergency, contact our front office **24 hours** before the scheduled appointment or the full therapy session fee may be assessed. Our office staff will then ask for your availability to reschedule the appointment.
- When an appointment is rescheduled it is expected that your child will attend that appointment. Multiple cancels and reschedules require reviewing the child's schedule and determining of another time may be more beneficial.
- In the event of inclement weather that may be a safety concern, contact our office if you are unable to make it to the appointment. A fee will not be assessed and a reschedule will be offered.
- Frequently canceled appointments (more than 2 canceled appointments of any discipline for every 8 scheduled) will be basis for removal for your reoccurring appointment schedule.

**No Shows:**

- Failure to cancel or appear during an appointment is considered a no show. A **$60** fee will be assessed for groups and **$150** for individual sessions. Please contact our office immediately to discuss future appointments.
- If we are unable to reach you within 3 days after a no show appointment, your child's appointment will be automatically offered to another child waiting for services.

**A Note from the Therapist:**

It is expected that families make every effort possible to attend scheduled appointments. When therapists establish a plan of care for your child, they base the goals and progress on your child having consistent therapy sessions (weekly). If your child misses appointments or arrives late, they may not meet their goals as quickly, and your child will likely need to be enrolled in therapy for a longer period of time. The success of treatment sessions depends on consistency and timeliness. In the event that a family does have to cancel, it is strongly encouraged that it be rescheduled.

I have read the attendance policy and understand the attendance expectations for my child.

Parent/Guardian Signature_____ ____ Date_____


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# Notice of Privacy Practices

**** This Notice describes how health information about your child may be used and disclosed and how you can get access to this information.

The federal government has legislated the Health Information Portability and Privacy Act (HIPPA). The new rules regulate the privacy and accessibility of health information regarding your child's care at Empower Pediatric Therapy. You may request a copy of your notice at any time. Any changes will be added to this form will be available to you. You may request a copy of this at any time.

**Use and Disclosure of Information**

**Treatment-** We may use or disclose your child's health information to plan a course of treatment that includes evaluation, goals and treatment approach. At times, your child's medical information may be reviewed by a student intern at our facility. In addition, your child's medical records will be provided to your health plan and referring physician. Your child may receive therapy services in the same room with another child. When in the treatment area or waiting area, your child's goals and data pertinent to your child's treatment may be discussed with other professionals and family members.

**Payment-** We may use and disclose your health information to obtain payment for services we provide to you/your family member. A bill may be sent to you or your health insurance payer. The information on the bill may obtain information that identifies you, your spouse or your child. This information may include the child's date of birth, diagnosis and procedures or supplies used.

**Appointments**- We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

**Check-In-** Your child's name may be called when checking in at our window. Your child's name will be written on a sign in sheet.

**Schools and agencies-** We may provide information requested for IEP's, MFE's and evaluations with other professionals. We may disclose your child's information to doctors and other health professionals in regards to your child's care with us.

**Other Permitted Uses and Disclosures** To public health authorities charged with preventing or controlling disease, injury or disability. We will notify appropriate persons if we suspect child abuse or neglect. We may need to provide medical information regarding your child to legal/judicial/administrative and law enforcement person. We may need to send you information regarding your child's care or billing issues through the mail. We may also send you information about groups and programs. This information may come in a marked envelope with our address on it. We will not use or disclose your child's health information without your written authorization.

**Patient's Rights**

- You have the right to view your child's health record and request a copy of it. There may be a copying and postage fee.
- You may be asked to show proof of guardianship or parent (driver's license, court order)
- You may request an amendment to your child's record. We are not required to make this change, but it will be noted in the record
- You may restrict anything in our privacy act by completing a restriction request form. We are not required to honor your request, but will make all efforts to accommodate reasonable requests. You may fax or mail this to us.
- Provide written authorization for uses and disclosures not otherwise permitted by law.

**Signature: _____**

**I have read and understand/agree with Empower Pediatric Therapy Privacy and Policy Act**.


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# Payment Awareness Notification

Empower Pediatric Therapy has made me aware that I must pay in full at the time of visit for services provided at Empower Pediatric Therapy.

**Child's Name**:_____

I choose to receive services at Empower Pediatric Therapy and will be responsible for payment at the time of visit.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____


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# Prescription for Therapy

Patient Name: _____

DOB:_____

☒ Evaluate and Treat **(Select one)**

_____ **Occupational Therapy**

_____ **Physical Therapy**

_____ **Speech Therapy**

**Referring Physician** (Please Print): Dr._____

I certify that these services are medically necessary and are authorized by me. I also certify that the patient's medical condition is sufficiently stable to permit safe therapy as described herein.

X_____ Date:_____

Physician Signature


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# Release of Information Form

Child's Name_____ Date of Birth _____

Parent/Guardian _____

Address _____ City/State _____

Zip Code _____ Phone Number _____ Date _____

- I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, (Child's Name) _____ to Empower Pediatric Therapy. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Empower Pediatric Therapy to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

Signature of Parent/Guardian:_____

- I hereby authorize Empower Pediatric Therapy to release therapy reports regarding my child, (Child's Name) _____, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other).

Signature of Parent/Guardian:_____


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# Sick Policy

Policy:

It shall be the policy of Empower Pediatric Therapy to abide by the following:

All patients, or parents or guardians of patients, shall telephone to cancel and reschedule appointments when the patient may have one or more symptoms of a contagious disease. This will aid in the protection of the health of the staff, other patients, and family members.

Symptoms:

Fever >100 degrees F
Vomiting / Nausea
Sinus Infection/Cold with yellow or green mucus
Open / Draining Lesion
Lice
Chicken Pox
Measles
Productive cough
Impetigo
Conjunctivitis / pink eye
Strep Throat
Diarrhea
Any Other Contagious Disease Not Listed

I agree to abide by the above stated policy:

Parent / Guardian Signature _____ Date_____


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# Waiver, Release, and Liability

I,_____

(Guardian) Please Print

Hereby affirm that my child,

_____

(Child's Name)

May participate in all activities at Empower Pediatric Therapy.

I certify that I am aware of the inherent dangers associated with participating in therapy and all activities at Empower Pediatric Therapy

I understand and agree that neither Empower Pediatric Therapy, nor its trustees, representatives, therapists, or agents may be held liable in any way for any occurrence in connection with my child's participating in therapy and activities.

As part of the consideration for participating in therapy, I hereby personally assume all risks in connection with participating in therapy or activities. I further agree to save and hold harmless representatives from any claim by me, or my family, estate, heirs or assignees arising out of Empower Pediatric Therapy to render or obtain such emergency medical care or treatment as may be necessary should any injury, harm, or accident occur while participating in therapy and activities.

I further state that I am of lawful age and legally competent to sign this affirmation and release; that I understand the terms herein are contractual and not a mere recital: and that I have signed this document of my own free act and coalition. I further state and acknowledge that I have fully informed myself of the content of this affirmation and release by reading it before I have signed it.

I have executed this affirmation and release on:

_____ Day of _____, 20_____.

Signature_____

(Guardian)



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# COVID-19 Acknowledgement and Waiver

I,_____ of _____,

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

acknowledge that I have read and understand Empower Pediatric Therapy's COVID-19 Policies and Procedures.

I hereby certify that in the event that anyone in my family/household contracts COVID-19, that we will not hold Empower Pediatric Therapy accountable.

I certify that I am aware and assume responsibility of the risk of participating in therapy and all activities at Empower Pediatric Therapy.

I understand and agree that neither Empower Pediatric Therapy, nor its employees, therapists, or agents may be held liable in any way for any occurrence in connection with my child's participating in therapy and activities at Empower Pediatric Therapy.

As part of the consideration for participating in therapy, I hereby personally assume all risks in connection with participating in therapy or activities. I further agree to save and hold harmless representatives from any claim by me, or my family, estate, heirs or assignees arising out of Empower Pediatric Therapy.

I further state that I am of lawful age and legally competent to sign this affirmation and release; that I understand the terms herein are contractual and not a mere recital: and that I have signed this document of my own free act and coalition. I further state and acknowledge that I have fully informed myself of the content of this affirmation and release by reading it before I have signed it.

I have executed this affirmation and release on:

_____

(Date)

Signature_____

(Parent/Guardian)



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