EMPOWER
PEDIATRIC THERAPY

New Patient Information

Child's Full Name: _____ DOB: _____ Sex: ☐ M ☐ F

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

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Cell #: _____ Work#: _____ Cell #: _____ Work#: _____

Email: _____ Email: _____

How did you hear of us? _____

Doctor Information:

Physician/Pediatrician (Name and Facility): _____

Physician Phone #: _____ Physician Fax #: _____

Insurance Information:

Please list insurance information for which the patient is a beneficiary, if you would like claims filed

Policy Holder's Name: _____ DOB: _____ Sex: ☐ M ☐ F

Insurance Company Name and Address: _____

ID #: _____ Group #: _____ Phone #: _____

Payment Awareness Notification

Empower Pediatric Therapy has made me aware that I must pay in full at the time of visit for services provided. I choose to receive services at Empower Pediatric Therapy and will be responsible for payment at the time of visit.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Empower Pediatric Therapy
1150 Blalock Rd. Houston, TX 77055
P: (713) 574-1373 F: (713) 574-3216
empowerpediatrictherapy.com

Patient Needs Assessment

Birth History Child was born at how many weeks? _____

Delivery: ☐ Vaginal ☐ With Forceps ☐ C-Section

Were there any complications? _____

Was your child placed in the NICU? ☐ Yes ☐ No; If yes, how long? _____

Please describe any other medical problems or complications at birth _____

Development History

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

Rolled over: _____ Crawled: _____ Pulled up to stand: _____

Babbled: _____ Drank from a cup: _____ Used spoon: _____

Sat alone: _____ Stood alone: _____ Dressed self: _____

Said first word: _____ Toilet trained: _____ Walked alone: _____

Medical History

Current diagnosis: _____

Hospitalizations: ☐ Yes ☐ No; If yes, please describe: _____

Surgeries: ☐ Yes ☐ No; If yes, please list: _____

Has your child's vision been evaluated? ☐ Yes ☐ No; If yes, when and what were the results?

_____

Has your child's hearing been evaluated? ☐ Yes ☐ No; If yes, when and what were the results?

_____

Previous psychological evaluation? ☐ Yes ☐ No; If yes, please describe: _____

Current Physician(s): _____

Medication(s): _____

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, Physical, or Speech Therapy before? ☐ Yes ☐ No

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 ☐ ST

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 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

Comments: _____

The following people live in our home:

Name	Relationship	Age

Does your child have a nanny? ☐ Yes ☐ No; If yes, what is the nanny's name? _____

How many years has the nanny been with your child? _____

Are there members of the child's extended family with which he/she has a particularly close relationship?

_____

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 your child.

Parent/Guardian Signature: _____ Date: _____

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 15 minutes late to 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.

Cancellations

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 the 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 fee** 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 expectations for my child.

Parent/Guardian Signature: _____ Date: _____

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, text messages, postcards or letters).

Check In: Your child's name may be called when checking in at our front desk.

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 with 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/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 not 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 to us.
- Provide written authorization for uses and disclosures not otherwise permitted by law.

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

Parent/Guardian Signature: _____ Date: _____

Release of Information Form

Child's Full Name: _____ DOB: _____

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

I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, _____, to Empower Pediatric Therapy. I understand that this information is 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: _____ Date: _____

I hereby authorize Empower Pediatric Therapy to release therapy reports regarding my child, _____, 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: _____ Date: _____

Waiver, Release, and Liability

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_____.

Parent/Guardian Signature: _____

Sick Policy

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

All patients, or parents/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 >100.4° F	Vomiting or Nausea	Sinus Infection
Cold with yellow/green mucus	Open or Draining Lesion	Lice
Chicken Pox	Measles	Productive Cough
Impetigo	Conjunctivitis / Pink Eye	Strep Throat
Diarrhea	Other Contagious Disease not listed	

I agree to abide by the above stated policy.

Parent/Guardian Signature: _____ Date: _____

COVID-19 Acknowledgment and Waiver

I, _____ (Parent/Guardian) of _____ (Child's Name) , acknowledge that I have read and understood 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

Parent/Guardian Signature: _____ Date: _____