Temple Memorial
PEDIATRIC CENTER

Temple Memorial Pediatric Center
1710 Moores Lane
Texarkana, Texas 75503
Phone (903) 794-2705
Fax (903) 793-1203

Date _____

Re: _____

Please have parent or legal guardian fill out the form(s) and return in the enclosed envelope. If legal guardian please include documentation of guardianship.

Evaluation(s) and/or therapy(s) will be scheduled when ALL of the following paperwork has been completed:

1) A completed admit package
2) Copy of current insurance card on file
3) Pre-authorization if applicable
4) Prescription from attending Physician
5) Physician's referral if applicable

One again ALL of the above MUST be completed before an evaluation(s) and/or therapy(s) will be scheduled.

If you have any questions please call.

Sincerely

Medical Records

Enclosure(s)

Temple Memorial
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Social Services Notice

Dear Patient/Parent

Thank you for the opportunity to serve your child. Temple Memorial Pediatric Center is a comprehensive outpatient rehabilitation center (CORF) and one of the many services that we provide include social services. Each new patient at the time of admission has the opportunity to schedule a consultation with our social service provider.

Social Services include the following:

- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care.
- Assessment of the relationship of the patient's medical and nursing requirements to his/her home situation, financial resources, and the community resources available upon discharge of services.
- Counseling and referral for casework assistance in resolving problems in these areas.

Please check the appropriate line with regards to our social services.

_____ Yes, I would like to schedule a consultation with the social service provider.

_____ No, I am declining a social service consultation at this time.

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

Temple Memorial
PEDIATRIC CENTER

General Information

Date: _____

Name of Informant: _____ Relationship to Child: _____

Child's Name: _____ Date of Birth: _____

Address: _____ Nickname: _____

_____ Home Phone: (_____) _____

Gender: ❒ Male ❒ Female Cell Phone: (_____) _____

Family's Primary Language: _____ Other languages spoken: _____

Reason for Referral: _____

Referred by: _____

Parent's Primary Concern: _____

Parent Information

Guardian's Name: _____ Guardian's Name: _____

Address (If different from above):_____ Address (if different from above): _____

_____ _____

Phone: (____) _____ Phone: (____) _____

Alternate Phone: (____) _____ Alternate Phone: (____) _____

Email Address: _____ Email Address: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Phone: (____) _____ Phone: (____) _____

Alternate Contact: _____ Relationship: _____

Phone: (____) _____ Alternate Phone: (____) _____

Prenatal and Birth History

Mother's age at birth of the child_____ Father's age at birth of the child_____

❒Biological Child ❒ Adoption ❒Foster care ❒Surrogacy
Age at adoption/foster care placement: _____

Pregnancy ❒ Single ❒ Multiples

❒Complications (Check all that apply):

- ❒Abnormal ultrasound
- ❒ Eclampsia/pre-eclampsia
- ❒ Gestational diabetes
- ❒ High fever
- ❒ Infection
- ❒ Lack of sufficient amniotic fluid
- ❒ Pre- term labor
- ❒ Other: _____

❒ Medications taken during pregnancy:_____

❒Prenatal exposure to ❒ alcohol ❒ tobacco ❒drugs ❒ other_____

❒ Maternal hospitalizations: because of _____
From _____ weeks gestation to _____ weeks gestation

❒ Breech Position

❒ Other: _____

Birth

Name of Hospital: _____ ❒Full Term ❒Premature Gestational Age: _____

❒ Vaginal birth ❒ Caesarean Section – Reason:_____

Birth weight: _____ Length: _____

Length of hospital stay: Mom_____ Child: _____

❒Complications (Check all that apply):

- ❒ Apnea
- ❒ Feeding/growth issues
- ❒ GERD/reflux
- ❒ Cyanosis (blue baby)
- ❒ Respiratory issues (specify):_____
- ❒ Jaundice
- ❒ Meconium aspiration
- ❒ Other: _____

Neonatal

❒ NICU Stay Hospital: _____ Length of Stay: _____

Please check all that apply

- ❒ Ventilator/Breathing tube
- ❒ Oxygen required
- ❒ Retinopathy of Prematurity
- ❒ Seizures
- ❒ Intraventricular Hemorrhage (IVH) Grade _____
- ❒ Reflux/Gastroesophageal Reflux Disease (GERD)
- ❒ Periventricular Leukomalacia (PVL)
- ❒ Additional Diagnosis: _____
- ❒ Hearing Screening Results ❒ Pass ❒Fail
- ❒ Vision Screening Results ❒ Pass ❒ Fail
- ❒ Difficulty Feeding
- ❒ Occupational Therapy
- ❒ Physical Therapy
- ❒ Speech Therapy

Feeding History and Diet

How does your child currently receive nutrition? Check all that apply:

❒ NG –Tube ❒ NJ Tube ❒ G- Tube ❒ Bottle (nipple type):_____
❒Sippy Cup ❒Adaptive Cup ❒ Open Cup ❒ Spoon/Fork
❒ Straw ❒ Hands

If your child receives tube feedings, please complete the following:

❒ Continuous Feeds: _____ cc/hour for _____ hours
Beginning Time:_____ Ending Time:_____

❒ Bolus Feeds: _____ cc/oz
Times Given:_____

What foods does your child currently take?

❒ Breast Milk ❒ Pureed Table Foods ❒ Ground
❒ Formula ❒ Soft Chewables ❒ Bite size pieces
❒ Stage 1 Baby Food ❒ Hard Chewables ❒ Chopped
❒ Stage 2 Baby Food ❒ Chewy Foods ❒ Thickened Liquids
❒ Stage 3 Baby Food ❒ Pediasure ❒ Table food (whatever the family eats)

How long does a meal (or for infants, a bottle) usually take? _____

Please indicate any known adverse/allergic drug and/or food allergies (e.g. penicillin, latex, gluten):_____
_____

Does your child display any of the following behaviors related to feeding?

❒ Frequent coughing/choking related to feeding
❒ Gagging/vomiting related to feeding
❒ Gurgly or "wet voice"
❒ Refusal behaviors (e.g. head turning) related to feeding
❒ Difficulty accepting foods of a certain texture
❒ Particular regarding food temperature
❒ Difficulty chewing
❒ Holding food in mouth
❒ Chewing difficulty
❒ Tongue thrust
❒ Sensitive to being touched on face or around the mouth
❒ Drooling ❒ occasional ❒ frequent ❒ constant
❒ Chronic respiratory problems
❒ Other (please describe any difficulties related to feeding/swallowing): _____
_____

Has the child had a swallow study by a speech pathologist? ❒ Yes ❒ No
If yes, Where: _____ When:_____
Results: _____

Social History

Primary Language spoken in the home _____ Secondary language_____

Who in the home speaks this language? _____

Does the child speak this language? ❒ Yes ❒ No Does the child understand this language? ❒ Yes ❒ No

What language does the child prefer to use at home? _____

Please list everyone who resides in the child's home:

Name	Age	Relationship

Please indicate the child's current educational program:

❒ Day care/ Head Start ❒Early Intervention ❒Preschool ❒Kindergarten

School Setting:

Name of School: _____ Grade: _____ Teacher:_____

Classroom Setting:

❒Regular Classroom ❒Self-Contained Classroom ❒ Mainstream/Inclusion

Therapy in the Educational setting: (please list frequency and duration)

OT _____ PT _____ ST_____

Therapy History

Please indicate any of the following services your child has or currently receives services-

Service	Eval	Date	Location	Notes:
ECI				
Occupational Therapy				
Physical Therapy				
Speech/language				
Neuropsychology				
Behavioral				

Medical Information

Primary Physician:

Name: _____ Address/Clinic Name: _____

City & Zip code: _____ Phone: (____) _____

Other Physicians:

Name: _____ Address/Clinic Name: _____

City & Zip code: _____ Phone: (____) _____

Name: _____ Address/Clinic Name: _____

City & Zip code: _____ Phone: (____) _____

Diagnosis/Concerns

Does the Child have a MEDICAL DIAGNOSIS? ❒ YES ❒ NO ❒ UNKNOWN

Diagnosis	Age at time of Diagnosis	Physician who Diagnosed

What is your greatest concern? _____

When did you become concerned? _____

What are your goals for treatment? _____

_____

Medications/ Precautions

Please list any medications your child is taking currently:

Medication:_____ Purpose:_____ Frequency/dosage:_____

Medication:_____ Purpose:_____ Frequency/dosage:_____

Medication:_____ Purpose:_____ Frequency/dosage:_____

Are there any medical precautions or allergies that the therapist should be aware of when working with your child?

_____

Does your child have any assistive devices (e.g. glasses, casts, wheelchair, communication devices?)_____

Speech, Language and Hearing Development

Do you have concerns about the child's hearing? ❒ Yes ❒ No

Is there a family history of hearing loss? ❒ Yes ❒ No If yes, please specify:_____

Date of last hearing test? _____ Where was it performed:_____
Results: ❒ Within normal limits ❒ abnormal ❒ unknown

Is there a history of middle ear infections? ❒ Yes ❒ No Number of infections/dates:_____

The child mainly communicates by: ❒ crying ❒facial expressions ❒babbling ❒gestures
❒ Words ❒two word phrases ❒sentences ❒other_____

Please give ages that the child did the following (leave blank if not yet attained):
Smiled _____ babbled _____ used single words (bye, cookie)_____
Combined 2 words (me juice) _____ used sentences _____
Engaged in conversations _____

Did the child's speech appear to develop normally and then stop for a period of time? ❒ Yes ❒ No
If yes, please specify_____

Does the child speak clearly? ❒ Yes ❒ No Details_____

Is the child understood by people outside the family? ❒Yes ❒No

What is the perception of the child's speech by others (e.g. babysitter, grandparent, teacher) _____
_____

What is/are the concerns with the child's speech: _____

What does the child do when someone does not understand him/her (give up, get angry, etc)? _____
_____

Do you do anything specific to assist your child with his/her speech? _____

Does the child.....

- Typically understand what is said to him/her? ❒ Yes ❒ No _____
- Follow simple directions without assistance? ❒Yes ❒ No _____
- Need directions repeated often? ❒ Yes ❒ No _____

Is the child aware of any speech problems he/she may have? ❒Yes ❒ No

What do you see as the child's most difficult problem at home? _____
At school? _____ In community? _____

Any other information you would like us to know:

Medical and Sensory History

Please indicate any of the following that the child is or has experienced—

- Food allergies — specify:_____
- Dietary restrictions — specify:_____
- Other allergies (seasonal etc) — specify:_____
- Surgery — specify type/dates:_____
- Seizures — Type/frequency? _____ Medication?_____
- Head Injury — Type/Date: _____
- Vision Impairment — Glasses or other assisted devices? _____
- Hearing impairments — Hearing aids? ❒ Yes ❒ No ❒LEFT ❒RIGHT
- Ear Infections — How many/how often? _____
- PE tubes in place — Date placed:_____ ❒LEFT ❒ RIGHT
- Dental concerns — Details: _____
- Tonsils/ Adenoids removed — Date:_____
- Tongue- tie release — Date:_____ Physician:_____
- Difficulty managing food/liquids — specify:_____
- Excessive drooling — _____
- Sensitivity to sounds — Over sensitive_____ _____ Under sensitive_____
- Sensitivity to odors — Over sensitive _____ Under sensitive_____
- Sensitivity to being touched — Over sensitive _____ Under sensitive_____
- Dislikes certain clothing — Specify:_____
- Fearful of movement — Specify:_____
- Avoids being messy — Specify:_____
- Decreased safety awareness — Specify:_____

Other information or details you would like us to be aware of: _____

_____

Activities of Daily Living

Do you have concerns...

About the child's eating skills (use of spoon/fork)? ❒Yes ❒No

About the child's dressing skills (getting undressed, managing buttons/snap/tie)? ❒Yes ❒ No

About the child's hygiene skills (bathing, teeth brushing, combing hair)? ❒Yes ❒ No

About the child's toileting skills (toilet trained or hygiene)? ❒Yes ❒No

About the child's sleeping patterns (length, special needs for sleep)? ❒Yes ❒ No

Comments:

Developmental and Motor Skills

Please provide age at which the child did the following as near as possible:

Rolled over _____ Sat alone: _____ Crawled _____ Stood alone _____

Walked _____ Ran _____ Rode a trike _____ Rode a bike _____

Drew with a crayon _____ Toilet trained _____ Tie shoes _____ Dressed self _____

Do you have concerns about the child's strength or coordination? ❒ Yes ❒ No

Details: _____

Which hand does the child most often use to hold a spoon or crayon? ❒ RIGHT ❒ LEFT ❒ NO preference

Please indicate items the child is able to use:

❒Spoon ❒fork ❒ knife ❒ open cup ❒hairbrush ❒ toothbrush ❒ crayon/pencil ❒ scissors

Does this child....

Move about in an unusual manner ❒ YES ❒ NO Details: _____

Appear clumsy ❒ YES ❒ NO _____

Use any special equipment ❒ YES ❒ NO _____

Behavioral/Emotional Development

Circle behaviors that have been and/or are currently observed:

Good, non demanding	Cries often/fussy	difficult to discipline	stubborn
Mood swings	prefers to be alone	resistant to touch	prefers to be alone
Repetitive behavior	poor eye contact	high activity level	low activity level
Difficulty sleeping	uncooperative	withdrawn	easily frustrated
Impulsive	difficulty in new situations	aggressive	floppy when held
Quiet or passive	willing to try new things	difficulty with change	tantrums
Self injurious behavior	separation difficulties	difficulty with peers	plays alone
Uncooperative	likes being held	restless	

Details_____

What methods work best to discipline the child? _____

What are the child's favorite activites/toys? _____

Other concerns regarding behavior or emotional development: _____

_____

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ADMISSIONS FORM

SECTION 1. PATIENT INFORMATION (Please Print)

First Name MI Last Name Date of Birth Age

Street Address City State Zip County

Gender (M/F) Race Primary Care Physician

Father's Name Mother's Name

Home Telephone# Alternate Contact #

Alternate Contact # Alternate Contact #

Email Address

SECTION 2. METHOD OF PAYMENT (Check All That Apply)

Group Health/Private Insurance _____ Self Pay_____ ECI____ Workers'Compensation _____ Other_____

Medicare_____ Medicaid_____, or have you applied for Medicaid in past 120 days?_____

(Please report eligibility change immediately & present copy of Medicaid ID card to receptionist at first visit of each month.)

SECTION 3. PRIMARY INSURANCE INFORMATION (Must Be Completed)

Name of Insured Address, if different from patient Telephone, if different from patient Relationship to Patient

Social Security # Date of Birth Employer Name Address Telephone #

Insurance Company Name Telephone# Policy/ID # Group# Medicare/Medicaid #

(Continued on second page)

SECTION 4 SECONDARY INSURANCE INFORMATION

Name of Insured	Address, if different from patient	Telephone, if different from patient	Relationship to Patient
Social Security #	Date of Birth	Employer Name	Address / Telephone #
Insurance Company Name	Telephone#	Policy/ID #	Group# / Medicare/Medicaid #

SECTION 5 TERTIARY INSURANCE INFORMATION

Name of Insured	Address, if different from patient	Telephone, if different from patient	Relationship to Patient
Social Security #	Date of Birth	Employer Name	Address / Telephone #
Insurance Company Name	Telephone#	Policy/ID #	Group# / Medicare/Medicaid #

FINANCIAL RESPONSIBILITY

I understand it is important that I provide Temple Memorial Pediatric Center with my most current and correct address information for my file. I am to advise Temple Memorial Pediatric Center anytime there is any change to my address, telephone or other contact information. It is my responsibility to provide the most current, correct insurance information. If I fail to provide current or updated information I understand I will be responsible for charges for services provided by Temple Memorial Pediatric Center. I also understand that I will be responsible for all charges incurred I will be responsible for all charges incurred if I choose to receive therapy not covered by my insurance and/or Medicaid.

ASSIGNMENT OF BENEFITS AUTHORIZATION

I authorize any holder of medical, or other information about me to release to the Social Security Administration, its intermediaries or other insurance carriers any information needed for this claim. I authorize this provider of therapy services to file for medical benefits due to me under any medical insurance or government benefit plans for which I am eligible. I also authorize payment of any medical benefits due me directly to the above named provider of services for services or equipment, which they provide subsequent to this date.

STATEMENT OF FACT

This is to advise Medicare and/or Medicaid recipients and/or Private Insurance beneficiaries that there are certain services and equipment, which may not be covered as medical benefits under their program. There is the possibility that certain services and/or equipment as ordered by your physician may fall into the non-payment classification. Therefore, please be advised by this Statement of Fact, that if this is the case, you will be held responsible for payment of services/equipment not covered, as well as any coinsurance or deductible due. These amounts normally will be expected at the time of service.

I, the undersigned, hereby certify that I have read and understand the above. Furthermore, I personally guarantee full and timely payment for all services rendered. Payment for services rendered is required at time of service unless prior arrangements have been made. I will be responsible for all charges incurred

Signature of Responsible Party _____ Date _____

TMPC Staff Signature _____

AUTHORIZATON FOR MUTUAL EXCHANGE OF INFORMATION

Name: _____ Case: _____

DOB: _____ SS#: _____

I hereby authorize a mutual exchange of information between Temple Memorial Pediatric Center and the following agencies. This includes copies of medical records, school reports, therapy reports, educational and medical evaluation reports. Information may be provided through written, verbal, audio, video, or electronic form.

I further understand that I have the right to revoke this authorization in writing at any time. This release is valid for one year from the date signed unless otherwise specified. I agree that a copy of this authorization be accepted with the same authority as the original.

LIST YOUR CHILD'S DOCTOR(S) & SCHOOL(S)

Name	**Address**

_____ _____

Signature of Client/Parent/Legal Guardian Date

_____ _____

Witness Date

Temple Memorial Pediatric Center
1710 Moores Lane
Texarkana, Texas 75503
PH (903) 794-2705
FX (903) 793-1203

Consent to Communicate with someone other than Patient About health and/or account information

Patient Name: _____ Case #: _____

Purpose of disclosure: Help provide aide in my child's health care.

I understand that to the extent any Recipient of this information is not a "covered entity" under Federal and Texas privacy law, the information may no longer be protected by Federal or Texas privacy law once it is disclosed to the Recipient and, therefore may be subject to re-disclosure by the Recipient.

I understand Temple Memorial Pediatric Center may not condition treatment on my completion of this authorization form.

This authorization will expire upon revocation by patient or patient's legal representative.

I may revoke this authorization form at any time. **Initials:** _____

I give Temple Memorial Pediatric Center permission to communicate my health and/or account information to: (List any and all persons you give Temple Memorial Pediatric Center permission to communicate with in the event you are unavailable).

*LIST ANY FAMILY OR FRIENDS THAT MAY BRING YOUR CHILD TO THERAPY

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of patient or patient's representative Date

Printed name of patient's representative: _____

Relationship of patient's representative to patient: _____

_____ _____
Witness Date

Therapy Provider List

Name _____ DOB _____

Does this child receive therapy from any source other than Temple Memorial Pediatric Center?
____ yes ____ no

If you answered NO please sign and return this form.

If you answered yes, please list all of the therapy programs in which your child participates. This information will be used to complete the authorization process and to assist therapist in setting up a more comprehensive program for your child.

Physical Therapy:

Therapist name: _____ Agency or School: _____

Times / week _____ Minutes / session _____

Therapist name: _____ Agency or School: _____

Times / week _____ Minutes / session _____

Occupational Therapy:

Therapist name: _____ Agency or School: _____

Times / week _____ Minutes / session _____

Therapist name: _____ Agency or School: _____

Times / week _____ Minutes / session _____

Speech Therapy:

Therapist name: _____ Agency or School: _____

Times / week _____ Minutes / session _____

Therapist name: _____ Agency or School: _____

Times / week _____ Minutes / session _____

_____ _____

Parent or Guardian Date

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INFORMED CONSENT FOR MEDIA RELEASE

The purpose and intent of this consent is to enhance the services and programs offered by
TEMPLE MEMORIAL PEDIATRIC CENTER

Serving people with disabilities throughout the ARK-LA-TEX
through publicity and community relations

Name:_____ **DOB:** _____

This will authorize TEMPLE MEMORIAL PEDIATRIC CENTER to release:

( ) Newspaper picture and/or information

( ) Television video and or information

( ) Slide show pictures and/or information

( ) Newsletter

( ) Website

( ) Social Media

( ) Billboards/Bulletin Boards/ Wall Photos

( ) None at all

( ) Other _____

This release is valid until revoked in writing

SIGN/DATE EVEN IF YOU DO NOT CHECK ANY CONSENTS

_____ _____

Signature of Client/Parent/Legal Guardian Date

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Communicable Illness Policy

Dear Client Parent:

You are aware of the public concern over various communicable illnesses. We strive to provide a healthy environment for all clients and staff, and specific procedures shall be applied for the prevention for communicable disease transmission.

While attending programs at Temple Memorial Pediatric Center, certain policies must be followed for your protection as well as the protection of your family, other clients and staff. We have clients with compromised immune systems that can't handle common illnesses. *Please be courteous and think of these clients when you or your child is sick.*

- When staff becomes concerned about possible illness, a client may be asked to stay home until symptoms clear, or an appropriate program adjustment is made.
- In case of contagious illness, a client may be required to stay home until a written statement is obtained from the client's physician noting that the client is free from contagious illness and may return to the Center, or until an appropriate program adjustment is made.
- *Cancel your child's appointment when you, your child or anyone else that comes to therapy sessions with you has had a fever within the last 24 hours. Please do not return to therapy until you have been without fever for 24 hours without medication (Tylenol/Ibuprofen).*
- If your child is found with head lice, you should check **all** members of the household because lice spread by walking from head to head. Clients may not attend therapy if live lice are present in their hair. If Temple Memorial Pediatric Center becomes aware of live lice in a client's hair, the parent will be notified to take the child home for treatment. Clients with live lice must be excluded from therapy and may return the day after treatment if there are no live lice present.
- When the Center's Medical Director or Administrators consider it necessary, examination and/or medical testing may be done prior to consideration of a client's continued participation in therapeutic programs.

I have read, understand, and agree to follow the communicable illness policy.

_____ _____

Signature of Client or Legal Guardian Date

FORM 1A

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Fax (903) 793-1203

Client/Family Representative Attendance
And Participation Agreement

Significant client/family representative attendance and participation is required. Obtaining the maximum benefit from comprehensive rehabilitation services is a team effort and the client and family representative is a vital and necessary member. Clients are admitted to Temple Memorial Pediatric Center programs only when their needs can be appropriately met. I agree to make the following commitments:

- To attend at least 75% of scheduled therapy. Our goal in therapy is to make progress. Your child will not make progress if he/she is not attending therapy on a regular scheduled basis. Also, insurance will not authorize therapy if your child is not making progress.
- To notify Temple when your child will be absent and specify the reason for the absence. After 3 "no shows" you will receive a letter for discharge. Conditions for continued therapy will have to be discussed with administration.
- It is very important that you bring your child at the correct time for therapy. Continued tardiness hinders your child's progress. Repetitive tardiness will result in consideration for discharge.
- To comply with home programs when assigned. To report positive or negative changes observed in the home so that therapy adjustments can be made. To assist in the therapy as requested.
- To let the Temple staff know when the client/family needs are not met as it applies to patient therapy and functioning.
- To comply with communicable disease policy and stay at home if you or any family member has a contagious illness until completely well.
- Due to safety concerns, you cannot drop your child off before their therapy starts. You must sign your child in wait until the therapist calls your child back before you leave. DO NOT let your child come in unaccompanied by an adult.
- If you leave the building, you must leave your contact number and return to pick up your child before their appointment is over. You will not be allowed to leave the building if you are tardy picking up your child. There is no supervision available for children after their appointment. **We will not be held responsible for unattended children.**

It is understood that if I fail to honor this agreement, Temple's Social Worker will contact me, by telephone or mail, and encourage me to honor the agreement. If there is no improvement in attendance or participation after two (2) weeks, Temple has the right to discharge me/my family member from therapy. Each appointment space is important and you will be discharged if you do not adhere to our Attendance Policy.

_____ _____

Client/Family Representative Date

FORM 1D

Temple Memorial Pediatric Center

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Temple Memorial Pediatric Center (TMPC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of TMPC. I understand that my diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. TMPC is not required to agree to the restrictions that I may request. However, if TMPC agrees to a restriction that I request, the restriction is binding on TMPC and its therapists.

I have the right to revoke this consent, in writing, at any time, except to the extent that TMPC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review TMPC's Notice of Privacy Practices prior to signing this document. Temple Memorial Pediatric Center Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the TMPC.

TMPC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____ _____

TMPC Staff Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

TEMPLE MEMORIAL PEDIATRIC CENTER

I hereby acknowledge receipt of my personal copy of the Temple Memorial Pediatric Center Privacy Practices policy. It is my understanding that the material in this policy is subject to change and the organization may supersede, modify, or eliminate information in this booklet at any time (an amended copy will be provided to you at that time).

I accept responsibility for contacting this site's Executive Director or the organization's Privacy Contact concerning any questions, concerns, or further explanations about my rights and/or the privacy of my protected health information.

_____ _____

Client (or client's guardian) signature Date

_____

Client's (or client's guardian) printed name

_____ _____

Intake Coordinator's signature Date

_____

Intake Coordinator's printed name

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IMPORTANT NOTICE

It is your responsibility to notify us with any and all changes concerning your insurance coverage. Failure to provide current information could result in your claim being rejected by the insurance company leaving an unpaid balance on your account. If your insurance denies because of information you did not provide us, then you are responsible for paying the full amount of the visit and you will be placed on hold until the account is settled. If you lose coverage or change plans, you must notify us immediately in order for us to continue treatment of your child. Should you have any questions, please do not hesitate to call our billing department at 903-794-2705.

I have read and received notice of the above policy and agree to provide Temple Memorial Pediatric Center with all necessary information as may be required in order to file and receive payment. I understand that I am liable for any portion of the claim that is not paid by insurance due to failure to provide current and correct information.

Signature of Client/Parent/Legal Guardian

Date