1710 Moores Lane
Texarkana, Texas 75503

Temple Memorial
PEDIATRIC CENTER

Phone: (903) 794 – 2705
Fax: (903) 793 – 1203

PATIENT ADMISSION FORM

PATIENT INFORMATION

Child's First Name | MI | Last Name | Date of Birth | Age

Mailing Address | City | State | Zip

Gender | Race | Primary Care Physician | Location

Father's Name | Phone Number

Mother's Name | Phone Number

METHOD OF PAYMENT (check all that apply)

Group Health / Private Insurance _____ Self Pay _____ Medicare _____ Medicaid _____

Other _____

INSURANCE INFORMATION

Primary Insurance

Subscriber's Name | DOB | SSN | Relationship to Patient

Address (if different from patient)

Employer Name | Address | Phone Number

Insurance Company | Policy/ID # | Group # | Medicaid #

Secondary Insurance

Subscriber's Name | DOB | SSN | Relationship to Patient

Address (if different from patient)

Employer Name | Address | Phone Number

Insurance Company | Policy/ID # | Group # | Medicaid #

INSURANCE INFORMATION (continued)

Tertiary Insurance

Subscriber's Name	DOB	SSN	Relationship to Patient
Address (if different from patient)			
Employer Name	Address		Phone Number
Insurance Company	Policy/ID #	Group #	Medicaid #

Please initial each statement and sign below.

FINANCIAL RESPONSIBILITY

_____ I understand the following statements

- I will provide Temple Memorial Pediatric Center with my most current and correct address information.
- I will inform TMPC of any changes to my address, telephone or other contact information.
- It is my responsibility to provide the most current, current insurance information.
- If I fail to provide current or updated insurance information, I understand I will be responsible for charges for services provided by Temple Memorial Pediatric Center.
- 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 or my family member 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 to 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 Medicaid recipients and/or private insurance beneficiaries that there are certain services and equipment that 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 that if this is the case, you will be held responsible for payment of services and/or equipment not covered, as well as any coinsurance or deductible due. These amounts normally will be expected at time of service.

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

_____ _____

Signature of Responsible Party Date

_____

TMPC Staff Signature

Temple Memorial
PEDIATRIC CENTER

Date: _____

Child's Name: _____ **DOB:** _____ **Age:** _____

PARENT/GUARDIAN CONTACT INFORMATION

Primary contact for scheduling & billing

Name: _____ Relationship to child: _____

Address (if different from child): _____

Phone Number: (_____) _____ Email Address: _____

Occupation: _____ Employer: _____

Secondary Contact

Name: _____ Relationship to child: _____

Address (if different from child): _____

Phone Number: (_____) _____ Email Address: _____

Occupation: _____ Employer: _____

ALTERNATE CONTACT INFORMATION

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

Phone Number: (_____) _____ Phone Number: (_____) _____

SOCIAL HISTORY

Primary Language: _____ Secondary Language: _____

List everyone who resides in the child's home

Name	Age	Relationship

School/Daycare: _____

Does your child receive therapy at school? ❑ Yes ❑ No ❑ Unsure

Has your child **previously** received therapy from any source other than Temple Memorial Pediatric Center?

❑ Yes ❑ No *If yes, list name of therapy agency* _____

and disciplines your child received *PT* *OT* *ST*

Does your child **currently** receive therapy from any source other than Temple Memorial Pediatric Center?

If yes, list name of therapy agency _____

❑ Yes ❑ No *and disciplines your child receives* *PT* *OT* *ST*

REFERRAL INFORMATION

Reason for referral: _____

Referring Physician: _____

Parent's primary concern: _____

_____

PRENATAL / BIRTH HISTORY

Mother's age at birth of child: _____ Father's age at birth of child: _____

❑ Biological child ❑ Adopted child ❑ Foster child ❑ Born via surrogate

Child's age at adoption/foster placement: _____

PREGNANCY HISTORY ❑ Single ❑ Multiples

Complications (check all that apply)

❑ Abnormal ultrasound
❑ Eclampsia / preeclampsia
❑ 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 ❑ Yes ❑ No Breech position ❑ Yes ❑ No

If yes, reason: _____ *from* _____ *weeks gestation to* _____ *weeks gestation*

Other pregnancy information _____

_____

BIRTH HISTORY ❑ Full term ❑ Premature *Gestational age:* _____ *weeks*

❑ Vaginal birth ❑ Caesarean section *Reason:* _____

Hospital: _____ Birth weight: _____ Length: _____

Length of hospital stay: Mom _____ Baby _____

Complications (check all that apply)

❑ Apnea
❑ Feeding/growth issues
❑ GERD/reflux
❑ Cyanosis
❑ Respiratory issues (specify) _____
❑ Jaundice
❑ Meconium aspiration
❑ Other: _____

NEONATAL HISTORY

NICU ❑ Yes ❑ No Hospital: _____ Length of stay: _____

NICU Complications / Interventions (check all that apply)

- ❑ Ventilator/breathing tube
- ❑ Oxygen required
- ❑ Retinopathy of Prematurity
- ❑ Seizures
- ❑ Intraventricular Hemorrhage (IVH) Grade ____
- ❑ GERD/Reflux
- ❑ Periventricular Leukomalacia (PVH)
- ❑ Difficulty feeding
- ❑ Occupational therapy
- ❑ Physical therapy
- ❑ Speech therapy
- ❑ Additional diagnoses _____

_____

- ❑ Hearing Screening: pass fail
- ❑ Vision Screening pass fail

DEVELOPMENTAL & MOTOR SKILLS

Please provide age at which the child met the following developmental milestones

Rolled over _____ Sat alone _____ Crawled _____ Stood alone _____

Walked _____ Stacked blocks _____ Use spoon/fork _____ Babbled _____

Point to object _____ First words _____

Which hand does the child use to hold a spoon or crayon? ❑ Right ❑ Left ❑ No preference

Indicate the items the child is able to use ❑ Spoon ❑ Fork ❑ Knife ❑ Open cup ❑ Hairbrush ❑ Toothbrush ❑ Crayon/pencil ❑ Scissors

SENSORY HISTORY

Please indicate if your child has issues with any of the following and provide details.

- ❑ Sensitivity to sounds _____
- ❑ Sensitivity to touch _____
- ❑ Sensitivity to odors _____
- ❑ Dislikes certain clothing _____
- ❑ Fearful of movement _____
- ❑ Avoids being messy _____
- ❑ Decreased safety awareness _____

Any other information or details to be aware of _____

_____

BEHAVIORAL / EMOTIONAL DEVELOPMENT

Indicate behaviors that have been and/or are currently observed.

- ❑ Good, non demanding
- ❑ Repetitive behavior
- ❑ Difficulty sleeping
- ❑ Uncooperative
- ❑ Prefers to be alone
- ❑ Poor eye contact
- ❑ Difficulty in new situations
- ❑ Willing to try new things
- ❑ Resistant to touch
- ❑ Withdrawn
- ❑ Aggressive
- ❑ Difficulty with peers

What methods work best to discipline the child? _____

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

Other concerns regarding behavior or emotional development? _____

_____

MEDICAL HISTORY

Does your child have a medical diagnosis? ❑ Yes ❑ No ❑ Unknown

Diagnosis	Age at Diagnosis	Physician who diagnosed

MEDICATIONS / PRECAUTIONS

Please list any medications your child is currently taking.

Medication: _____ Purpose: _____ Dose/Frequency: _____

Medication: _____ Purpose: _____ Dose/Frequency: _____

Medication: _____ Purpose: _____ Dose/Frequency: _____

Medication: _____ Purpose: _____ Dose/Frequency: _____

Are there are medical precautions therapist(s) should be aware of when working with your child? _____

_____

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

_____

MEDICAL HISTORY

Please indicate if your child has or has experienced any of the following and provide details

❑ Food Allergies _____

❑ Dietary Restrictions _____

❑ Other Allergies (seasonal, etc.) _____

❑ Surgeries *date/type* _____

❑ Seizures *type/frequency* _____

❑ Head Injury *date/type* _____

❑ Vision Impairment *glasses or other assistive devices?* _____

❑ Hearing Impairment *hearing aids* ❑ Yes ❑ No *type* _____ ❑ Left ❑ Right

❑ Ear Infections *number/frequency* _____

❑ PE Tubes in place *date* _____

❑ Dental Concerns _____

❑ Tonsils and/or Adenoids removed _____

❑ Tongue tie release *date* _____

❑ Difficulty managing food/liquids _____

❑ Excessive drooling _____

Any other information or details to be aware of _____

_____

Temple Memorial
PEDIATRIC CENTER

Notices, Policies, and Agreements

Patient name: _____ **Date of Birth:** _____

Please initial each statement and sign below.

____AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

- 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.

Please list your child's doctor(s) and school district.

_____

_____

_____

____CONSENT TO COMMUNICATE WITH SOMEONE OTHER THAN PATIENT ABOUT HEALTH AND/OR ACCOUNT INFORMATION

- 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.
- 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).

Name	Relationship
_____	_____
_____	_____
_____	_____

____INFORMED CONSENT FOR MEDIA RELEASE

I give permission for Temple Memorial Pediatric Center to use my child's photograph and/or information for social media, newsletter, website, bulletin boards, wall photos, and advertisements in newspaper, television, or slideshows. I understand this release is valid until revoked in writing. ❑ Yes ❑ No

____SOCIAL SERVICES NOTICE

Temple Memorial Pediatric Center is a comprehensive outpatient rehabilitation center (CORF). Each new patient has the opportunity to schedule a consultation with a 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 box in 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.

_____ _____

Signature of Responsible Party Date

Temple Memorial
PEDIATRIC CENTER

Notices, Policies, and Agreements

Patient name: _____ **Date of Birth:** _____

Please initial each statement and sign below.

____ COMMUNICABLE ILLNESS POLICY

Temple Memorial Pediatric Center strives to provide a health environment for all clients and staff. Many of our clients have compromised immune systems. Please be courteous and think of these clients when you or your child is sick. *By signing below, I have read the following statements and agree to follow the communicable illness policy.*

- 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.

____ CLIENT/FAMILY REPRESENTATIVE ATTENDANCE & 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.

_____ _____

Signature of Responsible Party Date

Temple Memorial
PEDIATRIC CENTER

Notices, Policies, and Agreements

Patient name: _____ **Date of Birth:** _____

Please initial each statement and sign below.

____ 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.

____ ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- 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.

____ INSURANCE NOTICE

It is my responsibility to notify TMPC of any and all changes concerning my insurance coverage. Failure to provide current information could result in my claim being rejected by the insurance company ***leaving an unpaid balance on my account, for which I will be responsible for.***

_____ _____

Signature of Responsible Party Date