ADVANCED PEDIATRIC
CARE CENTER

ADMISSION PACKET

This packet contains the following:

1. PPEC Intake Form
2. Pre-Admission document
3. Child Enrollment
4. Medical Information and History
5. Equipment and Supplies
6. Past Educational History
7. Release of Information
8. Consent for Placement and Treatment
9. Financial Authorization
10. Photo Permission Slip
11. PPEC Admission Orders
12. Application for Paratransit Services
13. PPEC Policies and Procedures for Parents
14. Confirmation of Parent Receipt of PPEC Policies and Procedures for Parents
15. Family Rights and Privacy Act

Please fill out documents as instructed and return with:

- A copy of recent School Entry Health Examination Form
- Up to date Immunization Record
- Social Security Card
- Health Insurance Card

Thank you and welcome to our PPEC!

ADVANCED PEDIATRIC
CARE CENTER

CONSENT FOR PLACEMENT AND TREATMENT

I hereby authorize the PPEC in consent and treatment for my child. I understand will provide services for my technologically dependent child. These services include, but are not limited to, developing, implementing and monitoring of a comprehensive protocol of care including medical, nursing, psychological and developmental therapies required by my child.

My responsibilities include providing the PPEC with the following supplies to be used or consumed by my child while at the center:

- All medical supplies
- Medications
- Diapers
- Wipes
- Food

It is also my responsibility to inform the PPEC of any changes in my child's medical care and of doctor appointments beforehand, if possible.

In case of an emergency, I give permission to the staff of The PPEC to treat my child. If I cannot be reached, I understand that emergency transportation will be provided by a licensed E.M.S. provider with a The PPEC staff member accompanying my child.

My hospital preference is: _____

I hereby request and give permission for the PPEC to provide medical and psychological examination and treatment as the staff deems best for my child's welfare. This may include an examination by the PPEC's Medical Director to ensure that our quality of service is maintained.

I release the PPEC and staff from any and all liabilities in regard to the care of my child except in the case of gross proven negligence. This authorization will remain in effect for continuing visits until permission is revoked by me.

Signed: _____ Relationship: _____

Child's Name: _____

Witnessed: _____ Date: _____

ADVANCED PEDIATRIC
CARE CENTER

CHILD ENROLLMENT FORM

CHILD'S NAME: _____ DATE OF ENROLLMENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

NAME	**ADDRESS**	**PHONE**
Mother: _____	_____	_____
Father: _____	_____	_____
Guardian: _____	_____	_____

Names and Ages of Siblings: _____

In order to ensure the safety of your child, we are requesting that you fill out the following authorization list. This list would include the people that you allow to pick up your child at the center or the people that we may leave your child with if they are dropped off by the bus. Anyone on the list should be prepared to show a photo ID. It is your responsibility to keep this list updated. Your child will not be left with someone who is not on the list without prior arrangement.

AUTHORIZATION LIST

Name: _____ Home #: _____ Work #: _____

Name: _____ Home #: _____ Work #: _____

Name: _____ Home #: _____ Work #: _____

Name: _____ Home #: _____ Work #: _____

Name: _____ Home #: _____ Work #: _____

Name: _____ Home #: _____ Work #: _____

Name: _____ Home #: _____ Work #: _____

ADVANCED PEDIATRIC
CARE CENTER

EQUIPMENT AND SUPPLIES

DOES YOUR CHILD EAT BY: ☐ **MOUTH** ☐ **GASTROSTOMY** ☐ **BOTH**

DOES YOUR CHILD HAVE ANY DIET RESTRICTIONS? ☐ **YES** ☐ **NO**
IF YES, PLEASE EXPLAIN:

_____

_____

PLEASE INDICATE IF YOUR CHILD USES ANY OF THE FOLLOWING EQUIPMENT:

- ☐ **CARDIAC / RESPIRATORY MONITOR**
- ☐ **PORTABLE SUCTION MACHINE**
- ☐ **OXYGEN**
- ☐ **O2 SATURATION**
- ☐ **NEBULIZERS FOR AEROSOL**
- ☐ **FEEDING PUMP**
- ☐ **GASTROSTOMY _____ TUBE SIZE**
- ☐ **TRACHEOSTOMY TUBE _____ SIZE**
- ☐ **WHEELCHAIR**
- ☐ **WALKER**
- ☐ **SPECIAL SEATING**
- ☐ **STANDER**
- ☐ **AFO'S**
- ☐ **SMO'S**
- ☐ **BRACES**
- ☐ **HEARING AIDE**
- ☐ **GLASSES**

PLEASE INDICATE IF YOUR CHILD HAS BEEN TESTED FOR THE FOLLOWING:

HEARING: ☐ **YES** ☐ **NO** **RESULTS:** _____
VISION : ☐ **YES** ☐ **NO** **RESULTS:** _____

FINANCIAL AUTHORIZATION

PATIENT NAME: _____

I UNDERSTAND THAT THE SERVICES BEING PROVIDED TO MY CHILD ARE NOT FREE AND ACCEPT THE RESPONSIBILITY FOR PAYMENT OF ALL OR ANY PORTION OF CHARGES NOT COVERED BY THE AUTHORIZATION SET FORTH BELOW:

1. _____ I AUTHORIZE MEDICAID TO BE BILLED. ID# _____

2. _____ I AUTHORIZE MY INSURANCE COMPANY TO BE BILLED:

INSURANCE COMPANY: _____

ADDRESS: _____

PHONE: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ CERTIFICATE NUMBER: _____

I AUTHORIZE THE RELEASE OF ALL RECORDS REQUIRED TO ACT ON THIS REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY CHILD'S BEHALF.

_____ _____

PARENT / GUARDIAN SIGNATURE **DATE**

_____ _____

WITNESS SIGNATURE **DATE**

ADVANCED PEDIATRIC
CARE CENTER

MEDICAL INFORMATION AND HISTORY

NAME	ADDRESS	PHONE
Pediatrician: _____	_____	_____
Neurologist: _____	_____	_____
Orthopedist: _____	_____	_____
Surgeon: _____	_____	_____
GI: _____	_____	_____
Other::_____ _____	_____	_____

DOES YOUR CHILD HAVE ANY ALLERGIES: ☐ **YES** ☐ **NO**

IF YES, PLEASE LIST (INCLUDE FOOD AND DRUG ALLERGY): _____

_____

_____

DOES YOUR CHILD HAVE A HISTORY OF SEIZURES? ☐ **YES** ☐ **NO**

PLEASE LIST PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES:

_____

_____

PLEASE GIVE BRIEF SUMMARY OF YOUR CHILD'S PERTINENT MEDICAL HISTORY:

_____

_____

_____

_____

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING (INCLUDE NAME, DOSAGE AND FREQUENCY):

_____

_____

_____

_____

_____

_____

ADVANCED PEDIATRIC
CARE CENTER

PAST EDUCATIONAL HISTORY

SCHOOL/PROGRAM	DATES ATTENDED	SERVICES RECEIVED			
		PT	OT	ST	NURSING
_____	_____	___	___	___	____
_____	_____	___	___	___	____
_____	_____	___	___	___	____
_____	_____	___	___	___	____
_____	_____	___	___	___	____
_____	_____	___	___	___	____

OTHER

Please describe any special needs or concerns regarding your child (such as positioning, feeding, likes and dislikes, etc.)

_____
_____
_____
_____
_____
_____
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_____
_____
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_____
_____
_____

ADVANCED PEDIATRIC
CARE CENTER

PHOTO PERMISSION SLIP

Dear Parent / Guardian:

We would like to take photos of your child: _____
and we would like your permission to include your child in the photos.

PLEASE CHECK the corresponding answer, fill in your child's name, and sign below:

☐ **The PPEC has my permission to photograph my child.**

☐ **I do NOT give The PPEC permission to photograph my child.**

Child's Name: _____

Parent / Guardian's Name: _____

_____ _____

Date Parent/Guardian's Signature

ADVANCED PEDIATRIC
CARE CENTER

PHOTO / TESTIMONIAL RELEASE FORM

I, _____ (hereafter known as the "Parent/Legal Guardian"). On my own behalf and on behalf of _____ (name of child)(hereafter known as the "child"). I hereby give the PPEC (hereafter known as "The PPEC"), its employees unrestricted permission to take, use my name and my child's name, testimonial and/or publish, distribute, project, display photographic images or pictures of my child(ren), whether still, single, multiple, or moving, or in which I (they) may be included in whole or in part, in color or otherwise, through any form of media (print, digital, electronic, broadcast or otherwise) at any PPEC center or elsewhere for advertising, recruitment, marketing, fundraising, publicity archival or any other lawful purpose. These photos and testimonials may be used in printed publications, multimedia presentations and on websites.

I waive any right that I may have to inspect and approve the finished product that may be used or to which it may be applied now and/or in the future, whether that use is known to me or my child(ren) or unknown.

I release and agree to hold harmless the PPEC, its officers, employees from any liability, any claim or cause of action, by virtue of taking of the pictures or using testimonial.

The person or persons signing this Release represent and covenant that 1) the person or persons signing have full authority in the jurisdiction in which the Release is executed to sign this release on behalf of the Child; 2) the person or persons signing this Release have carefully read the above Release prior to signing, and are fully familiar with the contents and consequences of it; 3) that this release is signed voluntarily under no duress and without expectation of compensation in any form now or in the future; and 4) this Release shall be binding without restriction as to time or otherwise upon the Child and his/her heirs, legal representatives, successors and assigns, as the case may be.

Printed Name: _____

Signature: _____

Child's Name: _____

Date: _____

PPEC ORDER FORM

Patient Name: _____

Medicaid ID: _____ DOB: _____

Legal Guardian: _____Phone:_____

Diagnoses:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ORDER: PPEC MON – SAT UP TO 12 HRS/DAY FOR 180 DAYS, PT, OT AND ST EVALUATION AND TREATMENT.

_____ _____

PHYSICIAN SIGNATURE **DATE**

Physician Name: _____ License #:_____

NPI: _____

Address:_____

Phone: _____ Fax:_____

ADVANCED PEDIATRIC
CARE CENTER

POLICIES AND PROCEDURES FOR PARENTS

The PPEC nursing staff at the PPEC strives to provide quality care for your child in a safe environment. The following are processes and procedures which must be followed to ensure your child's quality care in a safe environment. Your adherence to these policies is appreciated.

YOUR CHILD'S PRESCRIBED TREATMENT PLAN
Your child's treatment plan as prescribed by the physician to meet the individual needs of your child. This includes feedings, medications and treatments, therapies including PT, OT and ST, as well as such things as G-tube size, tracheostomy size, as applicable. Changes in any of the above cannot be done without a written physician's order.

Your compliance with the prescribed treatment plan will enable your child to reach his or her optimal level of well-being. Deviating from your child's treatment plan may put your child's health in jeopardy, as well as put your PPEC eligibility in jeopardy. We realize there may be changes from time to time. It is your responsibility to obtain a written doctor's order and inform us when these changes occur.

SUSPECTED RISK OF INFECTION
Any child who exhibits signs and symptoms or who is otherwise suspected of having infectious or communicable disease and or is considered to be present significant risk of infection to others will not be allowed to attend the PPEC. If the child is already in attendance at the PPEC he/she will be removed from contact with others and the parent will be notified to pick up their child immediately. The child will be returned to PPEC when the risk of infection is no longer present as evidenced by a written physician statement. Your corporation will greatly reduce the risk of infection to your child.

MEDICATIONS
In order to safely and accurately ensure that your child receives medications as prescribed all medications administered by the nursing staff must have a written doctor's order and must be labeled appropriately. This includes vitamins, supplements and over-the-counter drugs.

PARENT PICK UP
We request that you arrive at least 15 minutes before closing to pick up your child. This provides time to gather supplies and talk with the nurse about your child states and allows our stock to leave on time. We do realize that emergencies can occur. If you are unable to pick up your child as a result of an unexpected emergency, please call us immediately. However if we do not hear from the parent and alternate arrangements are not made, the PPEC staff may be left with no other option but to contact the police department and/or HRS.

BUS PICK-UP
All children up to 16 years of age must be restrained in a car seat/child carrier that is crash tested and federally approved. Children 4 years and older, up to the age of 16 years can be restrained by safety/seatbelt if the child is capable of maintaining an upright sitting position. This is in accordance with Florida's transportation/child safety law 316.614. If you are unable to provide an appropriate car seat/child carrier, contact your local law-enforcement agency and they will assist you. Your child will not be transported if they do not have the proper child restraint systems. It is the parent's responsibility to have your child and supplies ready for the bus arrival in the morning. Not having your child ready prolongs the time your child will spend on the bus and delays arrival to the PPEC for needed therapies, treatments, etc. Telephone calls for pick up should not be expected and I was there for emergency use only.

BUS DROP-OFF

ADVANCED PEDIATRIC
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It is the parent's responsibility to be home when the bus drops off your child. If an unexpected emergency occurs and this is not possible, please contact us immediately. Please keep in mind that you should allow a window of approximately one half hour before and after the usual drop off time to allow for unexpected (traffic, weather, mechanical breakdown, etc.) conditions. However, if a child cannot be dropped off as a result of a parent not being available at the time of drop off, the child will be returned to the PPEC center prior to closing time. If this is not done, the PPEC staff may contact the police department and/or HRS.

IMMUNIZATIONS

An update immunization record is required for your child's medical record up PPEC and the Dade County Public School Programs at the PPEC as well. Make sure you to obtain forms 680 and 3040 from your child's primary care physician and send them to the PPEC. Without these forms your child may not receive some services.

SUPPLIES

Please make sure your child is furnished with all the supplies he/she needs for the day. Feeding supplies, medications, diapers and wipes, adaptive equipment including orthotics, braces, and splints etc. should be sent from home. Unfortunately, if we do not have a supply on hand that your child needs, your child will not get it. Discuss with your nurse any questions you may have about what to send.

CONFIRMATION OF PPEC POLICIES/PROCEDURES AND CONSENT FORM FOR PARENTS

I have received a copy of the PPEC policies and procedures and consent form for parents and they have been discussed with me. I have read and understood them as outlined and I agreed to comply.

Signed: _____ Date: _____
(Parent/Guardian)

_____
Printed Name

I hereby give consent for my child, _____ to be transported via Medicaid transportation per guidelines outlined in the Miami-Dade Transit Application for Pediatric Extended Care Paratransit services.

I have received a copy of the Miami-Dade Transit Application for Pediatric Extended Care Paratransit services, which outlines the criteria for my child to be transported.

Signed: _____ Date: _____
(Parent/Guardian)

_____
Printed Name

_____ Date: _____
PPEC Admitting Personnel

ADVANCED PEDIATRIC
CARE CENTER

PPEC PRE-ADMISSION PLAN

NAME: _____ DOB: _____

PARENT / GUARDIAN NAME: _____

ADDRESS: _____

PHONE: _____ CELL: _____ OTHER: _____

CURRENTLY IN HOSPITAL: ☐ YES ☐ NO Name of Hospital:_____

DIAGNOSIS: _____

MEDICAID #: _____ INSURANCE #: _____

DATE APPROVED TO START: _____

PRIOR TO ADMISSION THE FOLLOWING PAPERS MUST BE SIGNED AND RETURNED BY PARENT/GUARDIAN, AND/OR PHYSICIAN (AS INDICATED):

- **TRANSPORTATION CRITERIA (Parents do not have to sign if child will be transported by parents)**
- **PHYSICIAN'S ORDERS**
- **ADMISSION PACKET**

(CHILD CANNOT START PPEC UNTIL FORMS ARE SIGNED)

SPECIAL INSTRUCTIONS: _____
_____
_____
_____
_____

_____ Date: _____
PPEC Admitting Personnel

Advanced Pediatric Care Center Inc.
8197 N. University Dr. Suite 5-6, Tamarac, FL 33321 O: 954-366-1990 Fax: 954-208-7431

RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____

TO:

You are hereby authorized to release Medical, Social, Academic, and/Psychological records pertaining to my child to Advanced Pediatric Care Center Inc. (PPEC)

This information will be utilized in the best interest of my child, and will not be released to any other person without written permission from me.

Signed: _____ Date: _____
(Parent/Guardian)

_____
Printed Name

_____
Address

This medical release of information will expire 5 years after date signed.

ADVANCED PEDIATRIC
CARE CENTER

APPLICATION FOR PEDIATRIC EXTENDED CARE PARATRANSIT SERVICE

_____ _____

Name **Medicaid Number**

I understand that the child identified above may be eligible for Medicaid sponsored non-ambulance transportation. I have carefully reviewed the transportation criteria listed below, and in my assessment, he/she meets the eligibility requirements. I have included in the prescribed pediatric extended care PPEC prescription for service the guidelines for daily pre- and post-transportation assessment of this child.

1. Children shall neither need nor expect to need medical attention en route. For these purposes "medical attention en route "shall include, but not be limited to, the following examples:
   a. Frequent assessment of respiratory difficulties, such as apnea, emergency need of oxygen.

   b. Frequent assessment of cardiac status, emergency need of cardiac monitoring, and/or cardiopulmonary resuscitation CPR.

   c. Performance of invasive therapeutic measures such as intravascular access, intravenous fluids, administration of medications and endotracheal intubation.

   d. Conditions rendering the patient uncooperative, and/or at risk for harm to himself or others, e.g. unstable (uncontrolled by medication) seizure condition, manic states, psychosis, drug overdose.

   e. Conditions that warrant acute monitoring of fluid and electrolytes or blood chemistry.

2. Children will receive daily pre-and post-transportation assessment by a registered nurse, licensed practical nurse, respiratory therapist or an emergency medical technician (RN, LPN, RT or EMT) as provided by the PPEC, in accordance with the physicians PPEC prescription of services to assess whether medical attention as expected or needed in route. In addition, prior to authorizing daily transportation, the medical technician will assure that the Child will not present risk of infections to other children's and/or personnel. At minimum, if the child does not meet criteria set forth herein the child shall not be transported by vehicle other than an ambulance, and the transportation attendant shall immediately notify the office of Special Transportation and other parties, which may include the child's parents and physician.
3. Children will be transported and well-ventilated, air-conditioned, smoke-free vehicles with age appropriate safety restraints.
4. Children requiring continuous feeding and/or continuous oxygen may be transported is medical attention is not required on route. Chronic ventilator dependent children may be transported with an RN, LPN, RT or an EMT who has been ventilator trained.
5. Bolus feedings, medications, intravenous fluids or hyper-alimentation and medical treatments must be scheduled as not to occur during transport.
6. The PPEC center shall provide the appropriate transport attendance in accordance with the following criteria RN, LPN, RT or EMT must be on the non-ambulance transportation vehicle whenever a PPEC child is transported.
7. All PPEC transport attendants must be trained in CPR (cardiopulmonary resuscitation)
8. Children should not spend more than two hours per vehicle per trip.

ADVANCED PEDIATRIC
CARE CENTER

9. The RN, LPN, RT or EMT on board will monitor any unanticipated medical emergencies and will be equipped to call and shall call 911 for emergency assistance in the event of an unanticipated medical emergency.

Any child not meeting the above transportation guidelines will be considered for other types of transportation or home health care services at the discretion of the State Medicaid Program Office.

PHYSICIAN ASSESSMENT FOR TRANSPORTATION

We need you to make a baseline assessment of this child's medical needs, if any, during transportation. Transportation will occur twice a day for maximum two hour period each time. Please read the transportation criteria carefully and make your assessment accordingly.

Can this child be transported in a non-ambulance transportation vehicle where I know medical attention is indicated or anticipated en route?

☐ YES

☐ NO

_____
Physician's Signature

_____
Physician's Name Printed

_____
Physician's Florida License Number

If not, provide an explanation of this child special transportation requirements below or on the reverse side of the sheet.

_____
_____
_____
_____
_____
_____
_____
_____

ADVANCED PEDIATRIC
CARE CENTER

FAMILY RIGHTS AND PRIVACY ACT NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
EFFECTIVE JANUARY 01, 2016

The privacy of your medical information is important to us. U.S. government regulators established privacy rules ("HIPAA") governing protected health information. This notice describes how your medical information can be used, and about certain rights that you have.

The PPEC Administrator oversees privacy matters. You can contact her at: 786-468-4003 if you desire further information, or have any questions or concerns.

Use and Disclosure of Protected Information
Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. If we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS.)

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. Under your health plan, we are required to provide them with a diagnosis code for your visits and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without specific notice to you, or written authorization by you. Our accountants may see your name, dates of treatment and procedure codes during audits of our books. We may use your information for financial services, quality assurance, risk reduction and claim management purposes with our professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you when:

1. required by law;
2. required for public health purposes;
3. required by law to report child abuse;
4. required by health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. required by law in judicial or administrative proceedings;
6. required for law enforcement purposes by a law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral directory;
9. permitted by law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of the armed forces of the United States.

We may contact you by mail or phone, at your residence to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable request, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided on the bottom of the Patient's Certification, Authorization to Release Information and Payment Request form.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Patient's Rights
You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information.

You have the right to request amendments of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by our written authorization, or as permitted or required under 45 CFR § 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Excel Physical Therapy Obligations
We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be made available.

If you wish to complain about violations of our privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States.

You may also file a complaint with us. Complaints should be directed to the PPEC Administrator. No retaliatory action will be taken against you for any complaint you may make.