Dear Parents,

Thank you for choosing Absolute Pediatric Therapy for your child's therapeutic needs.

Whether you are a current client or a new client to Absolute Pediatric Therapy, this packet serves as a means of communication with you regarding our policies, insurance information, and general information. Please read the enclosed information and feel free to ask questions at any time.

OUR MISSION:

Absolute Pediatric Therapy was founded with the sole purpose of providing children an opportunity to achieve their full potential while receiving individualized therapy services in a positive, caring environment. Our team is comprised of licensed professionals who work together to bring you the highest quality of Speech, Occupational, Developmental, and Physical Therapy services.

Please take the time to fill out the attached forms and return them promptly, in order for us to schedule your child's evaluation.

We encourage you to visit our website (absolutepediatrics.com) for frequently asked questions, explanations of therapy services provided, and testimonials. If you have any additional questions, please do not hesitate to call our office (479) 966-1776. Thank you, Absolute Pediatric Therapy.

Thank you,

Absolute Pediatric Therapy

CHILD INTAKE FORM

Intake Date__/__/___

Child Information

LAST NAME:	FIRST:	D.O.B:	SEX:
		/ /	M / F

HOME ADDRESS:	CITY:	STATE:	ZIP CODE:	HOME PHONE:

PARENT INFORMATION

MOTHER'S LAST NAME:	FIRST:	FATHER'S LAST NAME:	FIRST:

MARITAL STATUS: SINGLE ( ) MARRIED ( ) OTHER ( )

EMPLOYER NAME:	WORK PHONE:	CELL PHONE:

WORK ADDRESS:	CITY:	STATE:	ZIP:

REFERRING PHYSICIAN INFORMATION

LAST NAME:	FIRST:	TELEPHONE:

DOES YOUR CHILD HAVE A PRESCRIPTION: YES / NO

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME:	FIRST:	WORK/CELL PHONE:	HOME PHONE:

ADDRESS:	CITY:	STATE:	ZIP:

RELATIONSHIP: EMERGENCY CONTACT ( ) PARENT ( ) GUARDIAN ( )

Has your child ever received PT, OT, ST OR DT? Y / N If yes, when and where?

INSURANCE INFORMATION:

Primary Insurance Company: _____

Insurance Co. Address _____**Circle coverage: Family / Individual**

Group#_____ **and/or Subscriber#**_____

Name of Policyholder_____

Policyholders SS#_____ **DOB of Policyholder** _____/_____/_____

Policyholder Address (if different from client)

_____

Relationship to client _____ **Effective Date of Coverage** _____

Employer _____ **Occupation** _____

Secondary Insurance Company: _____

Insurance Co. Address _____**Circle coverage: Family / Individual**

Group#_____ **and/or Subscriber#**_____

Name of Policyholder_____

Policyholders SS#_____ **DOB of Policyholder** _____/_____/_____

Policyholder Address (if different from client)

_____

Relationship to client _____ **Effective Date of Coverage** _____

Employer _____ **Occupation** _____

Please bring your insurance card with you on your first visit so that we can copy it for our records. Please notify us if any of your personal or insurance information changes.

INSURANCE VERIFICATION FOR THERAPY BENEFITS

Therapy Benefits? **Yes No**

Are there limits to these Therapy benefits? **Yes No**

Number of Visits_____ **Dollar Amount**_____

Have any benefits been used this year? **Yes No**

Number of Visits_____ **Dollar Amount**_____

Does this plan have a deductible? **Yes No**

How much is this deductible? _____

How much of it has been met?_____

What percentage of the allowable charge is paid by insurance? _____

What percentage of allowable charge is patient responsibility? _____

Is there a co-pay? **Yes No**

If yes, How much?_____

ARE EITHER OF THE FOLLOWING REQUIRED FOR THERAPY TO BE COVERED?

PRIOR AUTHORIZATION/REFERRAL

The process for this varies depending on the insurance company. Typically, the doctor referring the patient to therapy submits a request for prior authorization to the insurance company. The insurance company then authorizes how much therapy they will cover.

REFERRAL/WRITTEN ORDER/PRESCRIPTION

Referring doctor gives this to patient to bring to therapy.

BILLING/INSURANCE:

As a courtesy, we do submit insurance claims for our patients. It is important that your insurance information be correct and current and that you notify our office of any changes in your coverage. Updated information is requested yearly. If claims are denied due to inaccurate or untimely information, you will be held liable for the charges incurred.

Covered benefits vary between insurance plans. Some insurance plans require pre authorization for therapy services. Therefore, make sure that you have written documentation or an authorization number prior to accepting treatment. It is your responsibility to understand the limitations and exclusions of your policy.

Clients will be expected to pay co-payment and/or deductibles at the time of service. Furthermore, I agree that by signing this document that I will be responsible for non-covered services, deductibles, co-pays or co-insurance.

Deductible or co-pay amount will be due at the time of each visit. We will charge the credit card on file for those services on the day of each visit.

We require a credit/debit card on file for all patients. If a credit/debit card is not available, cash or check payment must be made for one full month in advance.

Parent Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of insurance benefits be made on my behalf to Absolute Pediatric Therapy. I authorize medical information held by Absolute Pediatric Therapy to be released to the insurance company and agents as needed for billing purposes.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Coinsurance and the deductible are based upon the charge determination of the Insurance carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

Print Child's
Name_____

Print Parent's
Name_____

Sign Parent's
Name_____

The following are our policies that govern all insurance claims:

To expedite your child's care, we will submit claims to your insurance provider, but cannot guarantee the coverage of your services.

You (the parent or responsible party), will pay all past due portions of your charges not covered by insurance, specified by the insurance. Our office does NOT guarantee that your insurance company will pay on claims.

However, if for some reason, your insurance company pays differently than determined at the time of your visit, or your insurance claim is denied, you (the parent/ guardian) are then considered responsible for the full amount of the bill.

Insurance payments ordinarily are received within 30 to 60 days from time of submission. If your insurance company has not made payment to our office within 60 days, we request that you (the insured) pay the balance due, and then seek reimbursement from the insurance company when and if it is paid. I understand that the billing office will mail me a statement of services rendered once it's processed through my insurance company. This balance is then due within 30 days. Up-to-date credit card information is required for ALL patients.

Signature _____ **Date**_____

CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

Street Address (cont.):_____

City:_____ State:_____ Postal Code:_____

Country:_____ Email _____

Address:_____

Direct Telephone: (_____)_____-_____

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number:_____

Expiration Month:_____ Expiration Year:_____

Cardholder Signature X_____ Date____/____/____

Security Code:_____

I, _____, give my permission to Absolute Pediatric Therapy to charge copays, deductibles, or non-covered services to this credit card.

_____ _____

Signature Date

SICKNESS:

Clients will not be allowed to attend therapy at Absolute Pediatric Therapy if they have been sick and running fever in the last 24 hours. Your child must be fever free for 24 hours without the assistance of medications to decrease fever. With infections that are treated with antibiotics, at least 24 hours of antibiotics but be administered before your child is approved to come back to therapy. A written notice from a physician may be requested for medical excuse.

Parent signature needed here to acknowledge understanding of above attendance/cancellation policy

Signature: _____ **Date:** _____

Print Name: _____

CANCELLATION POLICY:

*Please note our cancellation policy requires **24-hour notice** unless there is sickness or other unforeseen emergency. Please call 479-966-1776 to notify us. You may contact your therapist IN ADDITION but YOU MUST CALL THE MAIN CONTACT LINE. In the case of emergency or illness, call us as soon as possible. No show fee of $40 for therapy session and $75 for evaluation will be billed to your account.*

**Please sign here that you understand cancellation policy.

_____ _____

Print Name **Signature**

Patient Authorization

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Absolute Pediatric Therapy.

In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations.

Initial:_____

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my child's diagnosis and wish him/her to receive treatment at Absolute Pediatric Therapy. I permit its employees and all other persons caring for my child to treat him/her in ways they judge are beneficial to him/her. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Absolute Pediatric Therapy to release information, verbal and written contained in my child's medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons to my child's treatment or payment for services provided.

I authorize Absolute Pediatric Therapy to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment.

The signature below certifies that I have read and understand the above information

Signature: _____

WAIVER FORM

I, _____ the parent or guardian of _____ (thereafter referred to as "my child") give permission for my child to participate in Absolute Pediatric Therapy programs and services.

I hereby release Absolute Pediatric Therapy principal owners, therapists, employees and representatives and all other individuals or organizations acting on behalf of Absolute Pediatric Therapy, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in Absolute Pediatric Therapy programs. This includes, but without limitation, any claim, demands or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/ therapy equipment during the program at an Absolute Pediatric Therapy center or at clients homes.

I understand that I should be present at all times during delivery of service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully and completely releasing, discharging and indemnifying Absolute Pediatric Therapy in connection with their programs from all liability as herein described.

Signed: _____ _____

Parent/Guardian Signature **Date**

HIPPA

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.

Federal Law (the Health Insurance Portability and Accountability Act (HIPAA)) requires that health care providers inform patients of their rights regarding how the provider may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Privacy Notice describes my privacy practices that relate to your protected health information. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health condition.

Your Health Record and Protected Health Information

Each time you receive medical care from me, a record of your visit is created. This record typically includes, but is not limited to, information such as your name, age, address, a brief medical history, symptoms, any test results, the treatment provided to you, treatment plans devised for your care, and notes on follow-up care to be performed. How your health care information may be used and what control you may exercise over the use of your healthcare information is described in this Privacy Notice.

Uses and Disclosures of Protected Health Information

I may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

Treatment: Your health information may be used or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations and procedures will be available in your medical record to all health professionals with access to it.

Payment: Your protected health information may be used to seek payment from your health plan, from other sources of coverage such as Medicaid, or from the Central Billing Office for Early Intervention Services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. An independent billing service may be used to manage claims and payments.

Health Care Operation: Your health information may be used as necessary to support the day-to-day activities and management of my practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality care. Other examples might include: training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Other uses and disclosures for health care operations may include:

Appointment Reminders: Your health information may be used to contact you, a family member or friend involved in your health care as authorized by you as a reminder that you have an appointment for therapy. I may also leave a message on your answering machine / voicemail system unless you tell me not to.

Individuals Involved in Your Care: I may disclose your protected health information to a family member who is involved in your medical care or an appointed translator in order to communicate information to you. You may object to these disclosures. If you do not object to these disclosures or I can infer from the circumstances that you do not object or I determine, in the exercise of my professional judgment,

that it is in your best interests for me to make disclosure of information that is directly relevant to the person's involvement with your care, I may disclose your protected health information as described.

Uses and Disclosures which you authorize: Other than as stated above, I will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that I have taken action in reliance upon the authorization.

Individual Rights

Although your health record is the physical property of the healthcare practitioner or Facility that compiled it, the information belongs to you. You have certain rights under the federal privacy standards. These include:

· The right to request restrictions on the use and disclosure of your protected health information
· The right to receive confidential communications concerning your medical condition and treatment
· The right to inspect and copy your protected health information
· The right to amend or submit corrections to your protected health information
· The right to receive an accounting of how and to whom your protected health information has been disclosed
· The right to receive a printed copy of this notice

My Duties

I am required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. I am also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, I reserve the right to amend or modify my privacy policies and practices. These changes in my policies and practices may be required by changes in federal and state laws and regulations. Upon request, I will provide you with the most recently revised notice on any visit. The revised policies and practices will be applied to all protected health information I maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that I maintain. As permitted by federal regulation, I require that requests to inspect or copy protected health information be submitted in writing. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

I encourage you to express any concerns you may have regarding the privacy of your information. If you would like to submit a comment or complaint about my privacy practices, you can do so by sending a letter outlining your concerns to:

Absolute Pediatric Therapy

You also have the right to express complaints to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date
This Notice is effective on or after January 1, 2015.

Name: _____ DOB: _____

ABSOLUTE Pediatric THERAPY

Therapy Intake Questionnaire

Please complete this questionnaire to the best of your knowledge. The more information you can provide the better that we can serve your child

Why are you coming in for a therapy evaluation? What are your concerns? What are you hoping to get out of the evaluation?

_____

_____

_____

_____

_____

_____

Who is your child's Pediatrician: _____

Does your child have a confirmed diagnosis? If so, what is it?

_____

Does your child have any health concerns that we need to know about?

_____

_____

Has your child had an evaluation by a PT/OT/SLP/DT before? **Y / N**

*(If **Yes** , please bring notes/evaluation to appointment)*

Educational Information

School/Educational program or daycare currently attending _____

Grade level _____

IEP or Early intervention Services, Early/Head Start received? **Y / N**

If yes, what are the services for? _____

_____

_____

Does your child's teacher or daycare provider have concerns about your child's development in any of the following areas?

Gross motor skills_____ Fine motor skills _____Social skills _____ Self-help abilities_____

Name: _____ DOB: _____

ABSOLUTE Pediatric THERAPY

Birth History

Child was born: **full-term / premature** _____

Vaginal / C-section

Complications: _____

Did your child stay in the NICU/how long? _____

Developmental History

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Rolled over								
Crawled								
Walked alone								
Walked up Stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								
Drank from cup								
Dressed self								

Name: _____ DOB: _____

ABSOLUTE Pediatric THERAPY

Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- ☐ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- ☐ Talks excessively, interrupts often, doesn't listen
- ☐ Low energy/fatigue
- ☐ Poor concentration
- ☐ Difficulty initiating tasks
- ☐ Difficulty completing tasks
- ☐ Difficulty following instructions
- ☐ Engages in impulsive behaviors (acts before thinking)
- ☐ Immature compared to peers
- ☐ Engages in physically dangerous activities
- ☐ Often argumentative with adults
- ☐ Often actively defiant to adult requests and rules
- ☐ Blames others for own mistakes
- ☐ Often angry or resentful
- ☐ Somatic complaints of not feeling well
- ☐ Excessive separation difficulties
- ☐ Easily frustrated
- ☐ Lies
- ☐ Steals
- ☐ Aggressive towards others
  - o Adults
  - o Peers
- ☐ Often depressed/irritable mood
- ☐ Often loses things, very disorganized compared to others his/her age.
- ☐ Shy
- ☐ Feeling of worthlessness or low self-esteem
- ☐ Withdrawn
- ☐ Overly anxious or fearful
- ☐ Sleeping too little/insomnia
- ☐ Sleeping to much
- ☐ Difficulty making decisions
- ☐ Cries easily
- ☐ Temper tantrums
- ☐ Rapid mood changes/mood swings
- ☐ Suicidal thoughts
- ☐ Excessive need for reassurance
- ☐ Poor appetite
- ☐ Overeats
- ☐ Explosive temper with minimal provocation
- ☐ Odd fascinations
- ☐ Unrealistic worry about futures events
- ☐ Substance abuse
  - o Drug
  - o Alcohol
  - o other

Please explain all checked items: _____

_____

_____

_____

_____

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Name: _____ DOB: _____

ABSOLUTE Pediatric THERAPY

D. Home Behavior:

How often is each of the following settings a *problem* for your child?

While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
When eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
When playing by him/herself	☐ Rarely	☐ Sometimes	☐ Frequently
When playing with siblings/other children	☐ Rarely	☐ Sometimes	☐ Frequently
When with a babysitter or daycare	☐ Rarely	☐ Sometimes	☐ Frequently
In public places (church, store)	☐ Rarely	☐ Sometimes	☐ Frequently
When in the car	☐ Rarely	☐ Sometimes	☐ Frequently
When told to do something he/she doesn't want to do	☐ Rarely	☐ Sometimes	☐ Frequently
During sit-down homework time	☐ Rarely	☐ Sometimes	☐ Frequently
When watching TV or playing video games	☐ Rarely	☐ Sometimes	☐ Frequently

Sensory Processing

Does your child struggle with sensory processing in the following areas?

Tactile avoidance or seeking (Ex. Avoids: Distress with grooming routines, dislike tags, seams in socks, or being messy / Seeks: touch everything, enjoy being messy)

_____

Auditory sensitivity (Ex. Cover ears with noises, become upset or startle easily to loud noises, tune out noise or not seem to notice when people are talking to them)

_____

Clumsy or uncoordinated (Ex. Trip or fall, have difficulty navigating curbs or stairs, be late with motor development, struggle with sports or ball skills)

_____

Avoids typical play of kids his/her age (Ex. Prefer to play alone, often avoids play with others, has difficulty tolerating change in their play routines)

_____

Emotionally reactive (Ex. Easily becomes upset, gets frustrated easily, has frequent meltdowns or tantrums, difficult to console)

_____

Name: _____ DOB: _____

ABSOLUTE Pediatric THERAPY

Difficulty with transitions (Ex. Melts down when asked to transition or stop activity, needs lots of assistance to stop activity and move on to the next task)

_____

Does your child struggle with fine motor skills? (Ex. Avoid play with small objects, have poor grasp on writing tools, avoid coloring)

_____

Does your child struggle with self-care? (Ex. difficulty with dressing, managing zippers/buttons/snaps, unable to tie shoes, poor grasp or use of fork/spoon, difficulty with bathing/grooming, decreased awareness of needing to use the bathroom, inability to wipe self)

_____

Does your child struggle with any of the following:

Walking / Running: _____

_____

Coordination / Balance: _____

_____

Strength / Flexibility: _____

_____

Sports / Other Injury: _____

_____

Does your child currently do any of the following: (please check all that apply):

❑ repeat sounds, words, or phrases over and over

❑ understand what you are saying

❑ retrieve/point to common objects upon request (ball, cup, shoe)

❑ follow simple directions ("Shut the door" or "Get your shoes")

❑ respond correctly to yes/no questions

❑ respond correctly to who/what/where/when/why questions

Name: _____ DOB: _____

ABSOLUTE Pediatric THERAPY

Your child currently communicates using: (please check all that apply):

❑ Body Language ❑ 2 to 4 word sentences

❑ Words (shoe, doggy, up) ❑ Other _____

❑ Sentences longer than 4 words

How much of your child's speech do you understand?_____

How much of your child's speech do others understand?_____

Does your child:

❑ Engage in turn taking ❑ Greet people arriving or leaving

❑ Initiate conversation ❑ Maintain a topic

Does your child currently…

_____ Use a pacifier?

_____ Choke on food or liquids?

_____ Put toys, objects or clothing in his/her mouth?

_____ Brush his/her teeth and/or allow brushing?

_____ Hold food in his/her mouth?

_____ Sleep with mouth open, or is his/her mouth open at rest?

_____ Snore?

_____ Drool?

_____ Eat in a messy manner?

_____ Have difficulty with use of a straw or bottle?

_____ Suck his/her thumb?

Is he/she a picky eater? ____ Yes _____ No

If so, please explain:

_____

_____

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Name: _____ DOB: _____

ABSOLUTE Pediatric THERAPY

Does your child currently…

_____ Repeat sounds, words or phrases over and over?

_____ Understand what you are saying?

_____ Retrieve/point to common objects upon request (ball, cup, shoe)?

_____ Follow simple directions

_____ Respond correctly to yes/no questions?

_____ Respond correctly to who/what/where/when/why questions?

_____ Ask questions of others?

_____ Communicate his or her basic wants, needs, and feelings?

_____ Comment on daily activities, objects, and people within his or her environment?

_____ Participate in conversations with others?

Please check below any/all forms your child currently uses to communicate:

_____ Body language

_____ Words (shoe, doggy, up)

_____ Sentences longer than four words

_____ Sounds (vowels, grunting)

_____ 2 to 4 word sentences

_____ Other

Please describe your child's strengths _____

_____

_____

What do you want us to know about your child that you are not comfortable talking about in front of your child during the evaluation?

_____

_____

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