IMPACT TALLAHASSEE
PRESCHOOL ACADEMY COMMUNITY THERAPY

1725 Hermitage Blvd.
Tallahassee, FL 32308
Ph.: (850) 325-6301
Fax: (850) 325-6302

PATIENT HEALTH QUESTIONNAIRE

Please answer all questions as thoroughly as possible so we have a better understanding of your child's needs.

TODAY'S DATE: _____

PATIENT CONTACT INFORMATION

CHILD'S NAME: _____ GENDER: MALE / FEMALE
(Please circle one)

DOB: _____ AGE: _____

PARENT(S)/GUARDIAN(S) NAME:

_____

ADDRESS:

_____

_____

_____

CONTACT INFORMATION:

HOME (_____)_____ WORK (_____)_____

CELL (_____)_____

EMAIL _____

PLEASE LIST AN ALTERNATE EMERGENCY CONTACT:

_____

ALTERNATE CONTACT PHONE NUMBER: (_____)_____

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WHAT SHOULD WE DO IN THE EVENT OF AN EMERGENCY?:

_____

CHILD'S PRIMARY CARE PHYSICIAN: _____

HOSPITAL PREFERENCE: _____

ALLERGIES (EX. FOOD, DRUG, LATEX):

_____

MEDICAL PRECAUTIONS:

_____

PATIENT'S MEDICAL HISTORY

CHILD'S DIAGNOSIS/DIAGNOSES:

_____

_____

_____

HEIGHT: _____ WEIGHT: _____

OTHER SPECIALISTS/PHYSICIANS/THERAPISTS:

_____

_____

_____

DAYCARE OR SCHOOL YOUR CHILD IS ATTENDING:

_____

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GRADE LEVEL: _____

PREGNANCY / BIRTH HISTORY: (ANY COMPLICATIONS BEFORE BIRTH?)

_____

_____

_____

AT HOW MANY MONTHS GESTATION WAS YOUR CHILD BORN? _____

WERE THERE ANY COMPLICATIONS AFTER BIRTH?

_____

_____

_____

PAST MEDICAL HISTORY / SURGERIES / HOSPITALIZATIONS:

_____

_____

_____

MEDICATIONS & REASONS:

_____

_____

_____

_____

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RECENT HEARING & VISION SCREEN (Include dates and results)

_____

HOW DOES YOUR CHILD COMMUNICATE? HOW DO YOU COMMUNICATE WITH YOUR CHILD?

_____

_____

_____

DESCRIBE CHILD'S DIET/ EATING HABITS/ FLUID INTAKE/ DIET MODIFICATIONS (IF APPLICABLE):

_____

_____

_____

DEVELOPMENTAL MILESTONES (Walking, crawling, sitting up, babbling, first words)

_____

_____

_____

WHAT ARE YOUR PRIMARY CONCERNS?

_____

_____

_____

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OCCUPATIONAL THERAPY SECTION

FINE MOTOR CONCERNS:

_____

DEVELOPMENTAL CONCERNS:

_____

SENSORY CONCERNS: PLEASE CHECK ALL THAT APPLY

- ☐ Dislikes clothing tags/ seams
- ☐ Dislikes being held or touched
- ☐ Becomes anxious when feet leave the ground
- ☐ Withdraws from bright/flashing lights
- ☐ Holds hands over ears to protect from sounds
- ☐ Doesn't like teeth brushing
- ☐ Avoids getting messy
- ☐ Dislikes swings/playground equipment
- ☐ Avoids eye contact
- ☐ Dislikes noisy environments
- ☐ Limited food choices
- ☐ Resists certain textures: (please describe)_____

PHYSICAL THERAPY SECTION

CHILD'S MILESTONES

Check what your child can complete. If you remember the age they started being able to complete the listed task, please include as well.

Skill		**Average Age of Acquisition**
Rolling back to belly		4 months
Rolling belly to back		6 months
Sitting alone with toy >1min		7 months
Crawling		8 months
Walking		12 months
Running		2 years
Jumping		2.5 years
Standing on one foot for 5 seconds		2.5 years
Riding a Tricycle		3 years
Hopping on 1 foot		4 years
Riding a Bike		6 years
10 sit-ups with no rest		10 years
10 push-ups with no rest		13 years

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PHYSICAL THERAPY RED FLAGS (Please check all that apply)

Fatigue / heavy breathing with walking around grocery store or any other light activity	
W-sitting	
History of falling	
Walking on tip toes	

LIST OF MEDICAL EQUIPMENT THAT YOUR CHILD IS USING (Braces, walker, crutches, wheelchair, etc.):

_____

_____

_____

SPEECH-LANGUAGE THERAPY SECTION

EAR INFECTIONS / HISTORY OF TUBES (how old and how many?):

_____

_____

FEEDING AND/OR SWALLOWING CONCERNS (Chewing difficulties, choking, coughing while eating, excessive drooling, etc.)

_____

_____

PREVIOUS SPEECH – LANGUAGE THERAPY:

_____

FAMILY HISTORY OF SPEECH-LANGUAGE THERAPY:

_____

HOW DOES YOUR CHILD REQUEST DESIRED ITEMS?

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_____

_____

_____

PRIMARY CONCERN(S) (Pronunciation of sounds, following directions, social interaction, etc.)

_____

_____

_____

_____

_____

_____

APPLIED BEHAVIOR ANALYSIS SECTION

BEHAVIOR CONCERNS: (please check all that apply)

- ☐ Aggression towards same-age peers
- ☐ Aggression towards adults
- ☐ Self-injury
- ☐ Elopement (leaving area)
- ☐ Holds hands over ears to protect from sounds
- ☐ Climbing
- ☐ Mouthing or consuming unsafe items
- ☐ Lining up objects
- ☐ Property destruction
- ☐ Tantrums (not age-typical)
- ☐ Movement stereotypy (hand flapping, spinning self/objects, jumping, etc.)
- ☐ Scripting (repeating same phrases)

Please provide any additional details below:

_____

_____

_____

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CANCELLATION CONTRACT

Procedures Form

_____

Name Date

_____

Home phone: Work phone: Cell phones:

The purpose of these procedures is to safeguard our therapists from losing valuable time that could be spent treating clients and to accommodate our kids that are on a waiting list. If a family is not being consistent with their appointments, we need to give others the opportunity to be scheduled.

We understand it's not always possible, especially when your child is sick, but please call ahead to cancel your child's appointment at least 24 hours in advance.

For those patients that do not give at least 24-hour notice or simply do not show three times in a 3-month period, your child will forfeit his/her permanent appointment to a new child. You will be put on the call-in list.

I have read and understand the importance of this Patient/Clinic contract. I will abide by the rules and limitations stated above.

_____

Signature Date

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DISCLOSURE OF INFORMATION

You may refuse to sign this authorization.

RECEIVING INFORMATION:

AGENCY: _____ PHONE: _____

ADDRESS: _____ FAX: _____

Contact Person: _____

DISCLOSING INFORMATION:

AGENCY: _____ PHONE: _____

ADDRESS: _____ FAX: _____

Contact Person: _____

Patient Name: _____DOB: _____

Records Requested

_____Medical (Diagnosis, Treatment, Prognosis)
_____Audiometric Assessment/Recommendations
_____Physical Therapy Reports
_____Occupational Therapy Reports
_____Speech-Language Assessment Reports/Data
_____Speech-Language Treatment Plans
_____Speech-Language Progress Reports/Data
_____Psychological Assessment Reports
_____Academic Test Scores/Reports/IEPs
_____Other: _____

I authorize the release of the requested information. I understand this is voluntary. I understand that if the organization authorized to receive or to disclose the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

I understand that my healthcare and payment of my healthcare will not be affected by my signing this form. I understand I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. I understand this authorization expires in 1 year from the date of this form, I understand I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before they received the revocation.

_____ _____ ____/___/___
Signature Relationship Date

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CONSENT FOR PARTICIPATION/INFORMED CONSENT WAIVER

IMPACT Therapy provides a specialized intensive exercise program for children with developmental, neurological, sensory, mental, orthopedic, and other types of disabilities. As one might expect, there is some element of risk involved with any physical activity/exercise, intense exercise program, and the use of all exercise equipment (including the Therasuit & the Universal Exercise Unit). Although the risk is greatly reduced with the use of safety equipment, proper supervision, training, and skilled trainers, there remains the risk of injury during participation in the center's activities.

Therefore, it is necessary to get your permission to allow _____ (Print Child's Name) to participate in the exercise program provided by IMPACT Therapy.

I, _____ (Parent/Guardian) hereby release IMPACT Therapy from any liability, claims, demands, & causes of action, now or in the future, resulting from soreness or injury however caused, occurring during or after my child's participation in the exercise program.

If requesting Applied Behavior Analysis services:

I, _____ (Parent/Guardian) consent for my child to participate in assessment services provided by a Board Certified Behavior Analyst (BCBA) at IMPACT Therapy. I understand that the results and specific goals identified by these research-based assessments will be fully disclosed to me prior to implementation with my child.

In signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statements & understand the inherent risks involved with participation in IMPACT Therapy's exercise program and give permission for my child to participate.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

_____ _____
Address Phone

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ALLERGY QUESTIONNAIRE

NAME: _____ DATE: _____

Does your child have other food allergies/sensitivities? _____ Yes _____ No

If "yes," please indicate how these food allergies/sensitivities are handled in your home. (Example: Anaphylaxis - total avoidance, okay as an ingredient or in limited amounts, child able to set limits related to allergy, etc).

_____

_____

Is your child allergic to certain foods such as fruit or nuts?

_____

Does your child have food sensitivities? _____ Yes _____ No

Has your child ever experienced itching, hives, swelling or symptoms like a runny nose wheezing, eye irritation or difficulty breathing after either of the following?

- A dental exam or procedure
- Contact with a balloon
- An exam by someone wearing gloves

_____ Yes _____ No

Have you ever been informed by a doctor that your child has a latex or rubber gloves allergy?
_____ Yes _____ No

Does your child have any other medical conditions that require dietary modification?
_____ Yes _____ No

Does your child have celiac disease or gluten intolerance? When were they diagnosed?

_____

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In your opinion, what is your child's level of compliance with the gluten-free diet?
_____ 100% _____ 75% _____ 50% _____ 25%

Does your child have difficulty following the gluten-free diet if you are not able to monitor or help him/her?
_____ Yes _____ No

What type of symptoms will your child have if he/she ingests gluten? Will he/she tell someone he/she is sick? _____ Yes _____ No

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PHOTO RELEASE

IMPACT Tallahassee will make every attempt to **NOT** include your child in individual or group pictures without written consent. We routinely use such photos to promote summer camp, website content, marketing materials, activities on our campus, and to request donations for scholarships to our schools.

Photo Release: I, _____ (Parent's Name) give IMPACT Tallahassee permission to use my child's photograph for the purposes of recruitment, advertising, public relations, obtaining grants, or other purposes related to the mission and word of Progressive Pediatric/IMPACT Tallahassee, as well as for the historical records of the organization.

Child's Name _____

Signature _____ Date_____

Print Name _____

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OBSERVATION PERMISSION

IMPACT Tallahassee will make every attempt to **NOT** include your child in individual or group observation without written consent. We routinely have student observers or camp tours.

Observation Release I, _____ (Parent's Name) give IMPACT Tallahassee permission to allow my child to be observed at IMPACT Tallahassee for the purposes of therapy, teaching, or parent touring of the facilities for the purpose of enrolling their child.

Child's Name _____

Signature _____ Date_____

Print Name _____

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HIPAA PROCEDURES FORM

Health Insurance Portability and Accountability Act

_____

Name Date

_____

Address City State

_____

Phone Number Cell Phone Number

_____

Email

The purpose of these procedures is to safeguard confidential information and to minimize the risk of unauthorized access, use or disclosure of patient information.
Confidentiality is extremely important.

- Any documents containing protected health information, personal information, and the patient's folders will not be left open or unattended in a public area.
- Any phone conversations held with a patient will be held in a private area, behind closed doors.
- No discussion regarding patients and their personal information will be held in open public areas.
- You will only access and use information necessary to complete an authorized task. No patient folders or copies of patient information will leave this office.
- All information or questions of the parent regarding a patient's therapy sessions should be redirected to a staff member.

I have read and understand the importance HIPPA's patient confidentiality. I will abide by the rules and limitations stated above.

_____

Signature Date

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SESSION AND TREATMENT ACCOUNTABILITY

Information provided to comply with the No Surprises Act ruling

FOR DISPERSEMENT TO ALL PRIVATE INSURANCE AND PRIVATE PAY CLIENTS

(This does not apply to clients with Medicaid Insurance)

Please be advised that while we do bill insurance, there is no guarantee that insurance will cover your sessions. **In the event that insurance does not cover any remaining costs, parents/guardians are responsible for payment for the balance owed.**

Please see below for the possible cost for Speech Therapy, Occupational Therapy, and Physical Therapy; *rates are determined by insurance company, not IMPACT*:

Private Pay: If insurance denies the therapy claim or IMPACT Therapy does not accept your insurance:

	Speech Therapy	Physical Therapy	Occupational Therapy
Evaluation	$200.00	$200.00	$200.00
Therapy	$125/60min, $62.50/30min	$125/60min, $62.50/30min	$125/60min, $62.50/30min

Blue Cross Blue Shield: Deductible rates if policy individual deductible is not met:

	Speech Therapy	Physical Therapy	Occupational Therapy
Evaluation	$127.58	$55.26	$61.78
Re-evaluation	$127.58	$37.63	$40.73
Therapy	$82.48	$73.37	$77.36

** Speech Therapy cost are a maximum estimate and dependent upon the procedure code billed*
** Once policy individual deductible is met, then policy 10% or 20% co-insurance will apply (specific to each policy)*
** If individual policy has a co-pay, the co-pay will be required in place of the deductible/co-insurance*

Tricare: Deductible rates If policy individual deductible is not met:

	Speech Therapy	Physical Therapy	Occupational Therapy
Evaluation	$195.40	$86.11	$91.23
Re-evaluation	$195.40	$58.90	$62.67
Therapy	$22.02/Unit	$30.91/Unit	$39.42/Unit

** Speech Therapy cost are a maximum estimate and dependent upon the procedure code billed*
** Unit is a 15-minute block of time; length of sessions are often 2 units (30 min) or 4 units (60 min)*
** Once policy individual deductible is met, then policy 10% or 25% co-insurance will apply (specific to each policy)*

I have read and understand the obligation for services rendered.

Signature Date

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MANDATORY REPORTER

A **mandated reporter** is a person who, because of his or her profession, is legally required to report any suspicion of child abuse or neglect to the relevant authorities. These laws are in place to prevent children from being abused and to end any possible abuse or neglect at the earliest possible stage.

Behavior analysts, Speech-Language Pathologists, Occupational Therapists, Physical Therapists, Music Therapists, and Teachers act in the best interest of their clients, taking appropriate steps to support clients' rights, maximize benefits, and do no harm. They are also knowledgeable about and comply with applicable laws and regulations related to mandated reporting requirements.

Signature _____ Date_____

Print Name _____

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PATIENT BILL OF RIGHTS

- A patient has the right to respectful care given by competent personnel.
- A patient has the right to every consideration of his privacy concerning his/her own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discreetly.
- A patient has the right to expect that all communication and records pertaining to his/her medical care should be treated as confidential except as otherwise provided by law.
- The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
- The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's next of kin or to another appropriate person.
- A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.
- The patient who does not speak English is permitted to bring an interpreter to his/her therapy sessions.
- The facility shall provide the patient, upon written request, access to all information contained in his/her medical records.
- The patient has the right to expect good management techniques to be implemented within the facility out of consideration for the use of the patient's time and to avoid the personal discomfort of the patient.
- The patient has the right to examine and receive detailed explanations of his bill.

_____

Signature Date