



GENERAL AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status.

PHOTOGRAPH CONSENT/RELEASE

I, _____, give /do not give Thera-Play Pediatrics and Harris Physical Therapy permission to take photographs/videotape of my child, _____. These photographs may be used for marketing purposes (brochures, mailers, commercials) or appear within the clinic.

TREATMENT CONSENT

I, being the parent or guardian of the above minor patient, hereby authorize and request the performance of therapeutic evaluation and/or treatment services for this patient by Thera-Play Pediatrics, Inc., Harris Physical Therapy, and its associated therapists.

I authorize Thera-Play and/or Harris Physical Therapy to:

- Perform evaluations and treatments that are reasonable, necessary, and advisable.
- Release any information concerning my child's treatment for the purpose of insurance benefits.
- Receive payment of insurance benefits otherwise payable to me.

POLICIES AND PROCEDURES

I have read and understand the policies and procedures of Thera-Play Pediatrics and Harris Physical Therapy and agree that compliance to these policies is important.

AUTHORIZATION FOR CONTACT

May we leave the following types of messages at your home, work, or cell phone numbers?

YES	NO	Office appointment changes/reminders
YES	NO	Therapy services
YES	NO	Payment requirements for upcoming appointments
YES	NO	Doctor correspondence
YES	NO	Referral information

Please list your first choice for contact/message information: Phone _____
Email _____

COMMUNICATION WITH DOCTOR/OTHER HEALTH PROFESSIONALS

I understand that the therapists associated with Thera-Play Pediatrics and Harris Physical Therapy can consult with my child's Primary Care Physician as well as other health professionals in order to enhance plan of care, ensure medical safety, or seek additional professional opinions.

MISSED APPOINTMENTS

The best care for your child is received when he or she attends consistent therapy sessions. After your second no-show and no-call, you will be charged for the session (\$20). After three no-shows without a call, your child's appointment time can be given to another child.

FINANCIAL POLICY

Payment is made when services are rendered by either cash, check, or insurance (co-payments, co-insurance, and deductibles included). If your insurance pays at 100% (Medicaid), we will be glad to bill that for you. We are in-network with Blue Cross Blue Shield and its subsidiaries. Please contact Erin, Emily, or Hannah for our sliding scale fee schedule for uninsured clients.

Knowledge of your funding source is your responsibility. Any changes to your funding source need to be reported immediately.

FUNDING

Primary Insurance Company _____ AR Medicaid Number _____
ID/ Policy Number _____ Effective Date _____
Group Number _____ AR Kids A Number _____
Full Name of Policy Holder _____ AR Kids B Number _____
Date of Birth of Policy Holder _____
SSN of Policy Holder _____

Secondary Insurance Company _____
ID/ Policy Number _____
Group Number _____
Full Name of Policy Holder _____
Date of Birth of Policy Holder _____
SSN of Policy Holder _____

I have read and understand the following policies of Thera-Play Pediatrics and Harris Physical Therapy. My signature indicates that I have been informed, and have been given opportunity to ask any questions regarding these policies.

- General Authorization
- Photograph Consent
- Treatment Consent
- Policies and Procedures
- Authorization for Contact
- Missed Appointment Policy
- Financial Policy
- Communication with doctor and other health professionals

Parent or Guardian Signature

Date

Child's Name



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Practices from time to time and that I may contact this organization at any time to obtain a copy of the Notice of Privacy Practices. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action on this consent.

Client Name.....

Relationship to Patient

Signature.....

Date.....

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

CLIENT NAME _____ MAILING ADDRESS _____

DOB _____

I, _____, hereby authorize the following _____ to disclose
(name of provider/plan)

From the records of the above named client to:

THERA-PLAY PEDIATRICS, INC
2603 Main Dr. Suite 3
Fayetteville, AR 72704
Phone (479) 856-6400
Fax (479) 856-6623

HARRIS PHYSICAL THERAPY
2603 Main Drive. Suite 3
Fayetteville, AR 72704
Phone (479) 966-4883
Fax (479) 445-6130

For the specific purpose of SPEECH, OCCUPATIONAL, PHYSICAL THERAPY EVALUATION AND TREATMENT.

"All medical records" includes any and all written information you may have concerning my health care and any illness or injury that I may have suffered, including but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, xrays, results of tests, and copies of hospital records pertaining to me.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the purpose of time needed to fulfill its purpose for up to one year, except for disclosures of financial transactions, wherein the authorization is valid indefinitely.

I understand that I can revoke this authorization at any time with written notification. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requestor of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided by state or federal law.

I understand that if my record contains information related to HIV infection, AIDS, or AIDS related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or women's, infant, and children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization, and will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits. However, if a service is requested by a non-treatment provider (i.e. insurance company), for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given.

If treatment is research related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization; a copy of this authorization shall be as binding as the original.

Signature of Client/ Guardian

Date

Relationship to client



**Speech - Occupational - Physical
PEDIATRIC THERAPY**

HISTORY

CHILD'S NAME	DATE OF BIRTH	AGE
SEX	PERSON PROVIDING INFORMATION	PHYSICIAN
CHILD'S ADDRESS	CITY, STATE, and ZIP	IS YOUR CHILD IMMUNIZED?
TELEPHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

FATHER'S NAME	AGE	OCCUPATION
MOTHER'S NAME	AGE	OCCUPATION
SIBLINGS IN THE HOUSE?	FAMILY HISTORY OF _ ADHD _ Learning Disabilities _ Autism/PDD _ Communication Disorders _ Hearing Loss	ARE PARENTS _ Living together _ Separated _ Divorced _ Remarried _ Married

PREGNANCY AND BIRTH HISTORY

	YES	NO	COMMENTS
Were there any illnesses, injuries, bleeding or other complications during this pregnancy? Please describe.			
Was this pregnancy full term? Please list gestational age and weight at birth.			
Was the delivery vaginal or cesarean? Were forceps/vacuum extractor used?			
Was there a need for oxygen or respiratory assistance?			

MEDICAL HISTORY

HAS YOUR CHILD HAD ANY OF THE FOLLOWING?	YES	NO	COMMENTS/ APPROXIMATE DATE
Frequent ear infections? Does your child have PE tubes?			
Reflux or difficulty keeping food down? Please describe. Does your child have irritability following feedings? Are there current or previous feeding or swallowing difficulties? Please describe.			
Cleft Palate? If repaired, please give date.			
Does your child have vision problems? Please give date of last vision screening.			
Does your child have a hearing problem? Please give date of last hearing screening.			

HAS YOUR CHILD BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?	YES	NO	COMMENTS/ APPROXIMATE DATE
Autism			
PDD			
Asperger's syndrome			
Apraxia of Speech			
Dysphagia			
ADD/ADHD			
Down syndrome Has he/she been diagnosed with Atlantoaxial instability? Are there any movement restrictions?			
Cerebral Palsy			
Seizure Disorder			
Spina bifida			
Muscular Dystrophy			
Traumatic Brain Injury			
Other genetic disorder			
Congenital anomalies			
Brachial Plexus injury			
Allergies (Please specify)			
PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING			

GROWTH AND DEVELOPMENT

	YES	NO	COMMENTS
Did your child bottle feed or breast feed?			
Did your child have sucking difficulties?			
Are there any issues with sleep patterns? If so, please explain.			

We understand that you may have forgotten exact ages when these milestones occurred. If your child has not achieved a skill but is actively learning it, please mark the skill as emerging.

WHAT AGE DID YOUR CHILD	APPROXIMATE AGE	COMMENTS	EMERGING SKILL
Roll over?			
Crawl?			
Sit Independently?			
Walk independently?			
Speak first word?			
Speak two word sentences?			
Drink from a cup?			
Use a spoon?			
Dress independently?			
Toilet train?			

DESCRIBE YOUR CHILD	YES	NO	COMMENTS
Is mostly quiet			
Is overly active			
Tires easily			
Talks constantly			
Impulsive			
Aggressive			
Resistant to change			
Has difficulty separating from caregiver			
Has nervous habits or tics			
Has poor attention span			

EDUCATIONAL BACKGROUND

	YES	NO	COMMENTS
Does your child attend school/ preschool? Where? How often?			
What grade is he/she in now?			
Does your child receive special education or therapies at school? (OT, PT, ST) Please specify.			
May we communicate with school staff?			