FUNctional Kids Therapy Center LLC

Outpatient Pediatric Intake Form

Child's name: _____ DOB: _____ Age: _____ M/F: _____
Current Diagnosis: _____
Street:_____ City:_____ State: ____ Zip Code: _____
Home Phone: _____ Preferred E-mail Address: _____

School Attended: _____ Grade: _____

Parent #1 name: _____DOB: _____ SSN: _____ Occupation: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Parent #2 name: _____DOB: _____ SSN:_____ Occupation:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Siblings that live in the home (gender and age)_____
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Language: _____ Language Spoken at Home: _____

Child's Primary Physician: _____ Address/Phone: _____
Child's Referring Physician: _____ Address/Phone: _____
Reason for Referral: _____

What are your primary areas of concern/What are you hoping for the OT/Speech/PT to address?
_____
_____
_____
_____

What are your goals for Occupational/Speech Therapy?
_____
_____
_____
_____

Please list any Medical Precautions/Allergies/Medications
_____
_____
_____
_____

Has your child's hearing been evaluated recently? (If yes, when, by whom, and what were the results?_____
_____
_____
_____
_____

Is your child receiving any other services (i.e. Speech, Physical Therapy, Special Education, Early Intervention)?
_____
_____
_____
_____

What (if any) special equipment does your child use?
Wheelchair: _____ Eye glasses: _____ Hearing Aids: _____ Braces: _____ Walker: _____

Communication Device: _____ Crutches: _____ Other: _____

Prenatal & Birth History:

Please list any significant prenatal or birth history (weeks gestation, birth weight, APGARS):
_____
_____
_____
_____

___Premature ___Full term ___Low birth weight ___Weeks Gestation ___Breech Birth ___C-section
___Emergency C-section ___Vaginal Birth ___Forceps Delivery ___Vacuum Delivery ___Preeclampsia
___Gestational Diabetes ___Breast fed ___Poor suction/latch ___Bottle fed ___Multiple Ultrasounds
___Oxygen at Birth ___NICU stay ___Duration in NICU____ ___ Jaundice: _____ Other:_____

Medical History:

Please list any significant illness, hospitalizations, etc... :
_____
_____
_____
_____

___Chronic ear infections ___Tubes ___Tonsils/Adenoid Surgery ___Reflux ___Surgeries: list above ___Poor weight gain

Developmental History:

___Colic ___Poor sleep ___Asthma ___Abnormal muscle tone ___Torticollis ___Asthma ___ Cardiac Issues
___Frequent antibiotic use ___Frequent fevers ___Compromised immune system ___Abnormal Lab results

Circle statement that best describes your child:

Didn't like tummy time or not placed much on belly	OR	Loved being on belly
Met all motor milestones on time	OR	Was/is developmentally delayed
Is clumsy	OR	Has always seemed athletic
Struggles with use of hands/fine motor	OR	Uses utensils and pencils easily
Avoids climbing, swinging, being upside down	OR	Seems to crave/love movement

When did your child do the following:

Skill	Age Skill Developed (months)
Sat up:	
Rolled over:	
Pulled up to stand:	
Belly crawled:	
Hands and Knees Crawling:	
Walking:	

Began Babbling	
Spoke First Word:	
Short Phrases:	
Spoke in Sentences:	

My child communicates using:
___ is non-verbal
___ single words
___ 2-3 word phrases
___ sentences

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc...):
_____
_____
_____

Academic History:

Does your child attend school? ____ If so, where? _____Grade:_____
Does your child have an IFS/IEP? _____

Check off all that apply to your child:
___Does well in school

___Does well with the exception of: _____ ___Is challenged by school
___Is challenged by writing
___Is challenged by reading comprehension
___is challenged by decoding

___Is not enrolled in school
___Receives resource/ tutoring for: _____ ___Is an A B C D F Student
___Is in a self-contained classroom

Please list any academic concerns you have:
_____
_____
_____

Please list any specific teacher concerns:
_____
_____
_____

Behavior/Social History:

Check off all that apply to your child
___Is social and engaging

___Is well behaved

___Follows directions well

___Is easy going

___Understands safety

___Makes good eye contact with adults and peers

___Pays attention

___Plays well with other children

___Does well with change

___Unable to self-calm

___Is aggressive ___Is oppositional

___Does not like new places/ people

___Does not like crowds

___Has difficulty with transitions

___Prefers to play alone

___Has difficulty listening

___Extremely sensitive to criticism

___Quickly escalates without apparent cause

___Has difficulty paying attention

___Has tantrums

___Poor coping skills

___Takes turns with peers

Please list any behavioral or social concerns:

_____
_____
_____

Evaluation & Therapy Services:

Please list any previous occupational/speech therapy evaluations completed and recommendations:

_____
_____
_____

Please list any previous psychological/neuropsychological/psych-educational evaluations completed and recommendations:

_____
_____
_____

*__Please note that YOU are responsible for knowing your co-insurance, co-pay and deductible amounts. Functional Kids is NOT responsible for these costs that are dictated/outlined by your insurance carrier__.

****Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, we reserve the right to report you to collections and cancel any subsequent appointments. You are responsible for any fees Functional Kids Therapy Center LLC incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on your account(s).**

My signature below is confirmation that I have informed FUNctional Kids Therapy Center LLC of all necessary information and have answered all questions truthfully and to the best of my ability.

_____ _____
Parent signature Date

☐ I have viewed and understand the "policy DVD for attendance and cancellation"

Initials: _____ Whitness: _____

FUNctional Kids Attendance Policy

FUNctional Kids Therapy Center wants to improve you and your child's quality of life through consistent and high quality care. Cancellations, especially those with less than 24 hour notice including no-call/no-shows limit your child's progress and our ability to care for others. Please call the main line at: (269) 223-7789. We ask for your full cooperation with the following policy:

- If you are unable to keep your scheduled appointment, we request that you notify us immediately so that your appointment can be rescheduled and another patient may take your slot. **You must call by noon the PREVIOUS WORKING DAY from your child's appointment to avoid incurring a cancellation fee of $25.00. If you no-show for your appointment there will be a $50.00 fee applied to your account that is due before scheduling any further appointments.**
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your Physician and Insurance/Third Party Payer.
- If you accumulate 1 no-show for the scheduled appointment this will result in automatic discharge and physician notification.
- Greater than 50% cancellation in a 30 day period will also result in loss of preferred afternoon or early morning time slot(s) until further consistent attendance is established.
- Functional Kids reserves the right to cancel appointments if insurance changes and if we are not notified. This includes loss of Medicaid coverage. It is YOUR responsibility to complete your coordination of benefits and know your insurance policy, deductibles, co-insurances, co-pays and any other limitations/benefits.

We believe that this policy is necessary for the benefit of all patients, so that we can continue to provide high-quality treatment and service to everyone.

If you should have any questions regarding this policy, please feel free to discuss them with your therapist.

Patient Signature:_____Date:_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **FUNctional Kids Therapy Center** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) and communicate/send information to other health care providers and schools.
(The Notice of Privacy Practices provided by **FUNctional Kids Therapy Center** describes such uses and disclosures more completely.)
You may specify below what specific providers below:

_____
_____

I have the right to review the Notice of Privacy Practices prior to signing this consent.
FUNctional Kids Therapy Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by written request.

With this consent, **FUNctional Kids Therapy Center** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out Plan of care, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

By signing this I give permission to relatives and ANYONE BRINGING MY CHILD TO THEIR APPOINTMENTS to receive information about my child and their care at FUNctional Kids
This individual is NOT allowed to receive information about my child due to legal limitations we can produce in writing to Functional Kids: _____

With this consent, **FUNctional Kids Therapy Center** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **FUNctional Kids Therapy Center** may e-mail me information, such as appointment reminder cards and patient statements. I have the right to request that **FUNctional Kids Therapy Center** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Please list below specialists and their fax or email you would like us to utilize.

_____

Patient Signature:_____ Date:_____

Additional Consent

I, _____ consent to the use of video/photos of myself or my child to assist in training professionals and providing comprehensive care for my child.

I, _____ consent to allowing the interaction between my child and other children in the therapy center during therapy appointments. I understand this consent is for therapeutic purposes and my demographic/personal information will not be shared with other families unless specifically authorized.