Pediatric Therapy Guidelines

Dress/Attire: Please bring your child in loose, comfortable clothing that is able to get soiled during therapy sessions. We may request to keep a change of clothing and/or a bathing suit and towel in the clinic for your child's use.

Observation: Your child's therapist(s) may request that a parent or caregiver be available at all times during treatment. You may observe therapy sessions with approval from the treating therapist. Please discuss any questions or concerns during the evaluation.

HIPAA: Please assist us in ensuring the privacy of our clients in the clinic by not interrupting therapist when they are treating or are with another patient. We are prohibited from giving out information on other patients, so please refrain from asking staff for that information.

Timeliness to Appointments: If you are going to arrive late to your appointment, please call and let the front desk know prior to the appointment. They will then inform the therapist of your anticipated arrival time.

Babysitting Charges: Please be in the clinic and available at least 5 minutes prior to the end of your child's therapy session. We will charge $1.00 per minute for childcare provided after the hour/visit ends.

Attendance Expectations: We value your child and their success, but success is dependent on consistent attendance. If you must cancel, please follow our cancellation policy. It is **your** responsibility to let the **front desk** know of any schedule changes.

Consistent Care: Information regarding missed appointments is sent to case managers and physicians, which could jeopardize your request for further treatment, especially Medicaid patients.

If you "Cancel", for three (3) consecutive appointments or do not maintain an 85% appointment attendance rate within a three (3) month period, your appointment times may be lost and your child may be discharged from therapy

If you "No Show", your appointment times may be lost and your child may be discharged from therapy.

Progress Reports: At the end of each therapy session, the therapist will meet to discuss your child's progress and any Home Activity that we recommend. Please remember that therapist may have another patient at the top of the hour and may not have more than a few minutes to discuss progress. If you have questions or would like to discuss your child in more detail, you may email your questions or make an appointment to meet with the therapist.

Scheduling: Although we try to consistently schedule your child with the same therapists, occasionally, your therapist may be out for continuing education, vacation or other reasons. In the event that your child cannot see one of our other therapists, we will make every effort to limit missed treatments, however it isn't always possible to avoid cancellations due to limited appointment availability.

Children Must Be Attended: Children must not be left unattended in the waiting room. All children must be accompanied by a parent/guardian or caregiver unless arrangements have been made with your therapist. Children may not go in the pediatric gym without a therapist.

Health Policy: If your child is sick and/or contagious within 24 hours prior to their scheduled appointment, please do not bring them to the clinic. Children must be on antibiotics and fever free for 24 hours prior to a scheduled appointment.

Treating Therapist: The staff of Reavis Rehab include "licensed therapists" (Typically Masters level) as well as "licensed therapy assistants". A Licensed therapist will complete all evaluations and work with you to develop the treatment plan. Your child may be seen by a "therapy assistant" if deemed appropriate by the evaluating therapist. Therapy assistants work under the direction of the Licensed Therapists.

Reavis Rehab

PEDIATRIC INFORMATION

Child's Name: ___________________________________ Date of Birth: _______________
Address: ____ Age: ________________________
____ Phone: ______________________

Parent's Name: _________________________________ Home Phone: _______________
SS #: _____________________ DOB: _________________ DL# & State: ________________
Address: _____________________________ Employer: ______________________________
_____________________________ Work Phone: (_____)_____________________
Email: _____________________________ Cell Phone: (_____)_____________________

Parent's Name: _________________________________ Home Phone: _______________
SS #: _____________________ DOB: _________________ DL# & State: ________________
Address: _____________________________ Employer: ______________________________
_____________________________ Work Phone: (_____)_____________________
Email: _____________________________ Cell Phone: (_____)_____________________
Emergency Contact: Name___________________ Phone: ____________ Relationship: _______
Parents Marital Status: ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed ☐ Single
If divorced, who has physical custody?__________________ Is it full or joint?_______________
Does the child live with both parents? ☐ Yes ☐ No
Are the biological parents different from the above mentioned: ☐ Yes ☐ No
If yes, who does the child reside with: ____
Is there contact with the biological parents? ____
Is there a caregiver that will be bringing the patient? ☐ Yes ☐ No. Can we release information to the caregiver? ☐ Yes ☐ No Name:____
What languages are spoken at home: ____

Siblings:
Name: ____ Age: _________________
Name: ____ Age: _________________
Name: ____ Age: _________________

Patient's Physician: ____________________ Phone #: _______________ Fax #: _____________

Patient was referred by: ______________________________ Phone: (_____)_______________
Reason for Referral/Current Concerns: ____
____
____
Is there a family history of similar problems: ☐ Yes ☐ No
Describe: ____

Medications List medications your child is currently taking		
Name	Dose	Frequency

Patient Name:______________________________

PREGNANCY

Pregnancy was ☐ Normal ☐ Problems

If complications occurred, what kind (check appropriately)

☐ Chronic disease	☐ Viral infection	☐ Rh incompatibility
☐ Vaginal bleeding	☐ Toxemia	☐ Hypertension
☐ Trauma	☐ Accident	☐ False Labor

Other: ____

____

Length of Pregnancy: ______________________ Time in Labor: ____________________

BIRTH

Weight: _______lbs.________oz. Apgar score: ________________

Special considerations (check appropriately)

☐ Cesarean	☐ Premature (# of weeks)	☐ Breech
☐ Baby rotated	☐ Rh negative	☐ Cord around neck
☐ Jaundiced	☐ Transfused	☐ twin 1st or 2nd born

Other: ____

____

Length of hospital stay: ___________________________ NICU ________________________

Special cares needed after birth (oxygen, incubator, tube feedings, surgery, etc)

____

____

INFANCY

Newborn behaviors: ____

Sleep habits (circle one): slept well slept restlessly hardly slept never napped

Other: ____

Feeding habits (circle one): ate well difficulty sucking difficulty swallowing

Other: ____

DEVELOPMENTAL MILESTONES

At what age did your child first:

Roll __________ Sit __________ Crawl __________ Walk __________ Babble __________

Finger food _________ Drink from a cup __________ Use spoon __________

Gain bowel control: day ______________ night____________

Gain bladder control day ______________ night____________

Developmental Concerns: ____

____

____

At what time of day is your child most alert: ____

Patient Name:____________________________

MEDICAL HISTORY

Ongoing health problems: ____

Current medications: ____

Food allergies: ____

Other allergies: ____

Major illnesses: ____

Surgical Procedures: ____

Hospitalization: ____

Diagnosed disabilities (medical, physical, emotional): ________________________________

History of ear infections: _______________________________ how many: _____________

Medication prescribed: ____

Were tubes placed: ☐Yes ☐No If yes, by whom: _______________________

History of Asthma: ☐Yes ☐No

HEARING

How does your child respond to sounds: ____

Does he/she dislike certain sounds, voices, music: ☐ Yes ☐ No

Describe: ____

Does your child have difficulty hearing: ☐ Yes ☐ No

Describe: ____

Does your child:

Talk in a loud voice: ☐ Yes ☐ No

Turn up the volume on the radio/TV: ☐ Yes ☐ No

Hear you if their back is turned: ☐ Yes ☐ No

Hear you talk to them from another room: ☐ Yes ☐ No

Has your child had a formal hearing evaluation: ☐ Yes ☐ No

Where: ____

Physician: ____

Results: ____

VISION

How does your child respond to light: ____

Any visual difficulties: ☐Yes ☐No

Describe: ____

Has your child had a formal vision examination ☐Yes ☐No

Where: ____

Physician: ____

Results: ____

ORAL MOTOR

Does your child gag easily with certain foods? ☐ Yes ☐ No If yes, which foods: ____

Is your child a picky eater limiting him/herself to particular foods or food textures?☐Yes☐No

If yes, which foods: ____

Patient Name:______________________________

TOUCH SENSITIVITY

Does your child react emotionally or aggressively to touch? ☐ Yes ☐ No

Does your child avoid going barefoot especially in grass or sand? ☐ Yes ☐ No

CURRENT CONDITIONS

Health: ____

Height: _____________________________ Weight: _______________________________________

Last Physical Examination: _______________________Physician: ________________________

Physical disabilities: ____

Does your child have difficulty with balance or fall often: ☐ Yes ☐ No

Does your child appear awkward or uncoordinated: ☐ Yes ☐ No

Does your child have seizures: ☐ Yes ☐ No

Does your child have difficulty copying designs, letters and/or numbers: ☐ Yes ☐ No

Does your child crave rocking or swinging: ☐ Yes ☐ No

Does your child have difficulty executing sequential tasks in dressing such as buttons, zippers, or tying shoes: ☐ Yes ☐ No

Does your child have difficulty with drawing, coloring, tracing, or cutting activities: ☐ Yes ☐ No

Does your child seem weaker than other children their age: ☐ Yes ☐ No

Is your child difficult to understand: ☐ Yes ☐ No

How does your child communicate: gestures, babbling, pointing, words, sentences

How does your child:

Sleep/nap: inconsistently	well	restlessly
Eat/drink: at regular intervals	at consistent intervals	Particular Foods
Consistent amounts	inconsistent amounts	Variety of Foods

Do you have concerns regarding your child's reading skills: ☐ Yes ☐ No

Describe: ____

Do you have concerns regarding your child's writing skills: ☐ Yes ☐ No

Describe: ____

Which of the following does your child exhibit aversive or negative behavior to:

_____Touch (ticklish, complaints of pain)

_____Auditory input (sound)

_____Visual input (light, colors)

_____Oral input (mouth)

Where does your child spend typical day and with whom:

____

Patient Name:______________________________
School/Day Care: ____________________________________ Phone: (______)____________
Teacher: ____ Grade: ________________
Is your child receiving Special Education Services: ☐ Yes ☐ No
What Services: _________________________________ How often: ______________
Has your child received PT, OT or ST in the past? ☐ Yes ☐ No
Which Therapy: __________________________How often: _______________________
Where did they receive therapy: ____

Describe his/her behavior response:
____
____

Does your child demonstrate signs of inattention, hyperactivity, impulsivity, or distractibility?
____
____

Does your child exhibit behavior problems which significantly impair functions at school, home, or social outings? ____
____

Other areas of concern you wish to address:
____
____

ADDITIONAL COMMENTS
____
____
____

Acknowledgement Form:

__________________________________ __________________________________
Signature of person completing form Printed name

__________________________________ __________________________________
Relationship to patient Date

INSURANCE INFORMATION

Patients Name:____ DOB:___________________________

Insurance Plan: ____ Effective Date: ____________________

Policy Holder Name: ______________________________ Holder DOB: ________________ Sex: __M __F

Policy Holder Address, City, State, Zip: ____

Relationship to Patient: ____________________________ Holder Phone: __________________________

****** PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. The parent/guardian who is present for office visits is the Billing Guarantor, please see below. ******

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I am responsible for any costs incurred in the collection of my covered dependent's account in case of default, including reasonable attorney fees and court costs.

NON-COVERED SERVCICES

I am aware that some services performed by Reavis Rehab and Wellness Center, Inc. my be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

DIVORCE/CHILD CUSTODY

Reavis Rehab and Wellness Center, Inc. will NOT honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgement, or the list (the "Arrangements"). Since Reavis Rehab and Wellness Center, Inc. is not party to these Arrangements, it is not obligated to the fincancial terms of the Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at Reavis Rehab and Wellness Center, Inc. is responsible for the payment co-pays, co-insurance, and deductibles at the time of service. This policy applies to whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then Reavis Rehab and Wellness Center, Inc. will STILL collect the applicable co-pays, co-insurance, and deductibles at the time of servcice from the Presenting Parent. Upon request, Reavis Rehab and Wellness Center, Inc. will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

BILLING GUARANTOR SIGNATURE / CONTACT INFORMATION

________________________________	________________________	Sex: __M __ F
Billing Guarantor Name (print)	Date of Birth (mm/dd/yyyy)	
________________________________	________________________	________________
Billing Guarantor Signature	Social Security Number	Date (mm/dd/yyyy)

Consent for Care and Treatment

I hereby authorize Reavis Rehab & Wellness Center, Inc., (Reavis), to provide care and treatment to me or my child, as prescribed by my physician. A representative of Reavis will explain my plan of care and/or treatment plan. I further understand that I and/or my family/Caregiver will receive instructions to assist with my care. I agree to notify my physician or others providing care of any adverse reactions or other significant events relating to my health.

Release of Information and Liability

I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release information needed for this or a related claim. I further authorize any holder of medical or other information about me to release such information as may be necessary for the completion of my claim for benefits under my group or individual insurance policy(s). We may disclose medical information to Third Party Providers as necessary for your care (DME, Prosthetists, etc.) This authorization shall release Reavis Rehab from all legal liability and shall stay in effect until revoked by me.

Liability for Payment

We bill your insurance as a courtesy. You will need to pay or make arrangements to pay your estimated co-pay or deductible today. If your insurance carrier does not remit within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund, you will be responsible for the amount of money refunded. I understand and agree that I am financially responsible for any deductible, co-pay, co-insurance or other amounts for services not covered by my insurance. I understand and agree that I am financially responsible for any amounts denied by my insurance for services or supplies provided to me.

I understand that my insurance coverage has been verified to the best of Reavis's ability. **A verification of eligibility, benefits, and/or authorizations is not a guarantee of payment** by my insurance carrier. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorneys' fees.

Assignment of Benefits

My Insurance Company is hereby authorized and directed to pay Reavis any and all benefits to which I am entitled, for services or supplies provided by Reavis. In the event that payment is made directly to me, I will promptly remit to Reavis. I understand a late charge of 18% APR will be charged on all past due accounts. I understand there is a $ 10.00 fee for billing co-pays/co-insurance not paid at time of appointments unless prior arrangements are made.

Medicare patients: I understand that Reavis accepts Medicare Assignment and I will not be responsible for any amounts over the Medicare allowable charges. I understand that, if applicable, my secondary insurance will be billed for any amounts not covered by Medicare. **I understand that Medicare will not pay for outpatient therapy services if I am receiving or begin receiving Medicare reimbursable Home Health services during the same period of time.** Medicaid or State reimbursed Homemaker/Home Health services are not affected.

Workers Comp. patients: The above liability does not apply to patients who are covered under Worker's Compensation. However, if benefits are subsequently denied, you will be held responsible for the total amount of charges for services rendered to you.

Third Party Claims: Patient will be responsible and billed for their claims if not settled one year after discharge.

I authorize Reavis Rehab & Wellness Center Inc. to be my representative and act on my behalf in any appeals with my insurance.

Photograph Release

Initial Here_________if you consent to visual/audio images of myself or my child for the purpose of treatment, education or promotional material, i.e. social networks, website, brochures/flyers and special events by Reavis employees, including, but not limited to photographs, digital images, drawing, renderings, voices, sound or video recordings, or audio clips.

☐ - I have been provided an opportunity to review the *Notice of Privacy Practices.*

☐ - I have reviewed and agree to follow the *Cancellation and No Show Policies*.

☐ - I have reviewed and agree to follow the *Pediatric Therapy Guidelines if applicable.*

______________________________________	______________________________________
Signature of Patient or Responsible Party	**Patient's Name (Please Print)**
______________________________________	______________________________________
Staff Witness	**Relationship** **Date**

(512) 310-POOL (7665) • Fax (512) 310-9228

RELEASE OF INFORMATION

Patient Name: ______________________________ Date of Birth: ______________

I hereby authorize ____ to release
(Name of clinic/facility/person/organization to release information)

information from the record of ____.
(Name of patient)

The information is released for the following purpose:

____

____

to: **Reavis Rehab & Wellness Center** ______________________
(Name of clinic/facility/person/organization to release information to)

Physical Therapy	**Speech Therapy**	**Occupational Therapy**
___ Patient Demographic Information and Insurance	___ Patient Demographic Information and Insurance	___ Patient Demographic Information and Insurance
___ History and Physical	___ History and Physical	___ History and Physical
___ Progress Notes	___ Progress Notes	___ Progress Notes
___ Progress Reports	___ Progress Reports	___ Progress Reports
___ Discharge Summary	___ Discharge Summary	___ Discharge Summary
___ Evaluation	___ Evaluation	___ Evaluation
___School Records	___School Records	___School Records
___Academic Record	___Academic Record	___Academic Record
___VI Reports	___VI Reports	___VI Reports
___APE Reports	___APE Reports	___APE Reports
___AI Reports/Hearing	___AI Reports/Hearing	___AI Reports/Hearing

*This release will be in effect until revoked in writing.

______________________ ____
Date Signed Patient's signature or authorized party

If Authorized Party, relationship to patient____