Reavis Rehab & Wellness Center

PEDIATRIC INFORMATION

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____
Address: _____ Age: _____
_____ Phone: _____

Mother's Name: _____ Home Phone: _____
Cell Phone:_____
Address: _____ Employer: _____
_____ Work Phone: (_____)_____

Father's Name: _____ Home Phone: _____
Cell Phone:_____
Address: _____ Employer: _____
_____ Work Phone: (_____)_____

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? _____
What languages are spoken at home?_____

Siblings:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Patient's Physician: _____ Phone #: _____
Patient was referred by: _____ Phone: (_____)_____
Has your child received PT, OT or ST in the past? ☐ Yes ☐ No
Which Type of Therapy: _____ How often: _____
Name of Therapy Clinic: _____
Where does your child spend their days and with whom?_____
School/Day Care: _____ Phone: (_____)_____
Teacher: _____ Grade: _____
Is your child receiving Special Education Services: ☐ Yes ☐ No
If Yes, What Services: _____ How often: _____

Medications List medications your child is currently taking		
Name	Dose	Frequency

CURRENT CONDITIONS

Health: _____
Height: _____ Weight: _____
Last Physical Examination: _____Physician: _____
Physical disabilities/challenges: _____

PREGNANCY ☐Was Normal ☐Problems

BIRTH Weight: _____lbs._____oz. Apgar score: _____
Special considerations (check appropriately)

☐ Cesarean ☐ Premature (# of weeks) ☐ Other Special Needs Care
☐ NICU ☐ Heart Problems
☐ Ventilator ☐ Poor Suck

Other Medical Complications at birth: _____

INFANCY

Sleep habits (circle one): Slept Well Slept Restlessly Hardly Slept Never Napped
Feeding habits (circle one): Ate Well Difficulty Sucking Difficulty Swallowing
Other: _____

DEVELOPMENTAL MILESTONES

At what **approximate** age did your child first? (months/years)
Roll _____ Sit _____ Crawl _____ Walk _____ Babble _____
Finger food _____ Drink from a cup _____ Use spoon _____
Gain bowel control: day _____ night_____
Gain bladder control day _____ night_____

MEDICAL HISTORY

Ongoing health problems: _____
Food allergies: _____
Other allergies: _____
Major illnesses: _____
Surgical Procedures: _____
Hospitalization: _____
Known Diagnoses: (i.e. Downs Syndrome): _____
History of Asthma: ☐Yes ☐ No

HEARING

How does your child respond to sounds?_____
Does your child have difficulty hearing: ☐ Yes ☐ No
If YES, Describe: _____
History of ear infections: _____ how many: _____
Medication prescribed: _____
Were tubes placed: ☐ Yes ☐ No If yes, date and by whom: _____
Has your child had a formal hearing evaluation? ☐ Yes ☐ No
Where: _____
Physician: _____

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 themself to particular foods or food textures? ☐ Yes ☐ No

If yes, which foods: _____

Communicates by: ☐ gestures ☐ babbling ☐ pointing ☐ words ☐ sentences

How does your child:

Sleep/nap:	☐ Inconsistently	☐ Well	☐ Restlessly
Eat/drink:	☐ Regular Intervals	☐ Consistent Intervals	☐ Particular Foods
	☐ Consistent amounts	☐ Inconsistent Amounts	☐ Variety of Foods

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? _____

_____

Is there a family history of similar problems: ☐ Yes ☐ No

Describe: _____

IF YOU ANSWER YES, DESCRIBE ON NEXT PAGE:	YES	NO
Does your child have difficulty with balance or fall often:		
Does your child appear awkward or uncoordinated:		
Does your child have seizures		
Does your child have difficulty copying designs, letters and/or numbers		
Does your child crave rocking or swinging		
Does your child have difficulty executing sequential tasks in dressing such as buttons, zippers, or tying shoes		
Does your child have difficulty with drawing, coloring, tracing, or cutting activities		
Does your child seem weaker than other children their age		
Is your child difficult to understand		
Do you have concerns regarding your child's reading skills		

Do you have concerns regarding your child's writing skills		
Does your child react emotionally or aggressively to touch		
Does your child avoid going barefoot especially in grass or sand		
Talk in a loud voice		
Turn up the volume on the radio/TV		
Hear you if their back is turned		
Hear you talk to them from another room		
Does he/she dislike certain sounds, voices, music?		

_____
_____
_____
_____
_____
_____
_____
_____

Reason for Referral/Current Concerns: _____
_____

I certify that all information provided is to the best of my information and knowledge.

_____ _____
Signature of person completing form Date

_____ _____
Relation to patient Staff Witness

Cancellation and No-Show Policy

We regard this very seriously at Reavis Rehab & Wellness Center. Consistent treatment can make the difference in whether your therapy is successful or not. Your doctor and/or therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is one of your most important responsibilities.

Notification of missed appointments is sent to your Case Manager and Primary Physician. If you are non-compliant, this could jeopardize your request for further treatment especially for Medicaid, Worker's Compensation and Personal Injury patients.

Please understand that your symptoms or pain may increase or decrease through your treatment.

Either condition can seem to be a reason not to come in:

a) You're feeling worse and think the treatment is not working.
b) You're feeling better and it's a great day for wind-surfing.

Neither of these conditions is legitimate as a reason not to come:

a) If you're in pain, come in and get it fixed.
b) If you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and/or educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are injured: You, because you don't get the treatment you need as prescribed by the doctor and the therapist, who now has a space in their schedule since the time was reserved for you personally, and another patient, who could have been scheduled for treatment if you had given proper notice.

Please Read and Initial

_____ • If you must cancel an appointment, please do so by giving 24 hours notice. We do encourage rescheduling your appointment if possible. It is essential to keep your regular schedule for treatment to be successful. Understanding that emergencies do occur, it is our policy that any **cancellation with less than 3 hours notice will result in a charge of $30.00**. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.

_____ • If you must cancel or reschedule an appointment, please contact the **Front Desk** by phone: 512-310-7665. Voicemails may be left 24 hours a day. Please notify **ONLY** the front desk of any cancellations, *notifying your therapist and not the front desk will still result in a $50.00 no-show fee*. All emails and voicemails will be returned to confirm the cancellation. **If you do not receive a confirmation from the front office, your appointment has not been cancelled and you will be charged the $50.00 no-show fee.**

_____ • **If you do not show up or "NO-SHOW" for your appointment and do not give notice, you will be charged a fee of $50.00**, your scheduled appointment times will be "Cancelled" and you may be discharged from therapy.

_____ • If you Cancel for three (3) consecutive appointments, especially multi-discipline therapies, your appointment times may be "Cancelled" and you may be discharged.

_____ _____

Patient Signature Date

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**

Reavis Rehab
& Wellness Center

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) REQUIRED

_____ _____ _____

Billing Guarantor Signature Social Security Number REQUIRED Date (mm/dd/yyyy)

Pediatric Therapy Guidelines

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.

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. Frequent schedule changes will jeopardize your right to scheduling in advance.

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

Attendance Rate: You must maintain an 85% appointment attendance rate within a three (3) month period or your appointment times may be lost and your child may be discharged from therapy

If you "No Show" for 3 consecutive appointments, than your appointment time will be lost and your child will 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.

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.