reactive
PEDIATRIC
THERAPY LLC

Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

PATIENT INTAKE FORM

Patient Name: _____ **Age:** _____ **Gender:** _____

DOB: _____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Parent/Guardian Name: _____

Home Phone #: _____ **Cell #:** _____

Email*: _____

Emergency Contact: _____ **Phone #:** _____

Referred By: _____ **Reason for Referral:** _____

Diagnosis: _____

Primary Doctor: _____

Address: _____

Phone #: _____ Fax #: _____

Insurance Information

Insurance Name: _____

Member ID #: _____ Group Name/#: _____

Policy Holder Name: _____ DOB: _____

Relationship to Patient: _____

reactive
PEDIATRIC
THERAPY LLC

Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

Background Information

Patient Name: _____

Parent(s)/Guardian(s): _____ DOB: _____

Gender: Male / Female

PCP (referring physician): _____

Patient lives with (check one):

☐ Birth Parents ☐ Adoptive Parents ☐ Foster Parents ☐ Guardian ☐ Other

Language spoken at home: _____

Any language other than English spoken at home? ☐ Yes ☐ No _____

Please list the name, age, and relationship of those (other than parents) living in the patient's home:

Name	Age	Relationship to Patient

Does your child currently have a diagnosis? ☐ Yes ☐ No

If yes, what is it? _____ _____

Does your child attend a school or daycare? ☐ Yes ☐ No

If yes, where and current grade level?

_____

Does your child have an Individualized Education Plan (IEP)? ☐ Yes ☐ No

If yes, we will need a copy of the patient's most current IEP.

reactive
PEDIATRIC
THERAPY LLC
Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

What special services does your child receive?

_____

Birth History

Pregnancy / Delivery

Pregnancy Proceeded ☐ With Complications

☐ Eclampsia
☐ Gestational Diabetes
☐ Multiple Births
☐ Positive for Cytomegalovirus 'CMV'
☐ Positive for Herpes
☐ Positive for HIV
☐ Positive for Strep B
☐ Pre-eclampsia
☐ Premature Labor
☐ Substance Exposure
☐ Toxemia
☐ Other Without Complications

Prenatal care was: ☐ Received ☐ Not Received

Mothers age at time of birth: _____ Hospital Name: _____

Needed to be transferred to another hospital ☐ Yes ☐ No

Delivery Proceeded ☐ With Complications

☐ Abruptio Placenta
☐ Breech Presentation
☐ Negative Vacuum
☐ Placenta Previa
☐ Premature Rupture of Membranes
☐ Prolapsed Cord
☐ Without Complications
☐ Transverse Presentation
☐ Umbilical Cord Wrapped Around Neck
☐ Use of Forceps
☐ Uterine Rupture
☐ Other _____

reactive
PEDIATRIC
THERAPY LLC
Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

Delivery was ☐ Vaginal ☐ Emergency C-Section ☐ Scheduled C-Section

# of Days in Hospital_____

Pregnancy: ☐ Full Term ☐ Premature (____# weeks) Birth Weight: _____

Following Birth

Complications Following Birth

☐ Anemia of Prematurity

☐ Bronchopulmonary Dysplasia 'BPD'

☐ Cleft Lip

☐ Cleft Palate

☐ Club Foot

☐ Cytomegalovirus

☐ECMO

☐Failure to Thrive

☐Hyperbilirubinemia

☐Intrauterine Growth Retardation IUGR

☐IVH Bleed Grade 1

☐IVH Bleed Grade 2

☐IVH Bleed Grade 3

☐Meconium Aspiration

☐ Necrotizing Enterocolitis 'NEC'

☐ Neonatal hypoxia

☐ Oxygen dependency

☐ PDA

☐ Positive dependency

☐ respiratory distress syndrome

☐ Respiratory Stridor

☐ Respiratory Syncytial Virus 'RSV'

☐ Retinopathy of Prematurity 'ROP'

☐ Ventilator Dependency

☐ VP Shunt

Any Diagnosed or Suspected Syndrome?

_____

_____

reactive
PEDIATRIC
THERAPY LLC

Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

Any conditions during pregnancy?

_____

_____

Use of alcohol, tobacco, or medications during pregnancy?

_____

_____

Health Issues

☐ Anoxic Brain Injury

☐ Arteriovenous Malformation 'AVM'

☐ Asthma / Respiratory

☐ Cerebral Vascular Accident 'CVA'

☐ Chronic Ear Infections

☐ Colic

☐ Constipation / Diarrhea

☐ Reflux

☐ Seizure Disorder

☐ Sleep Problems

☐ Traumatic Brain Injury 'TBI'

☐ Tube Feeding

Explanation:

_____

_____

Are immunizations current? ☐ Yes ☐ No

Please list any medications your child takes regularly:

Medication	Frequency	Dosage

Does your child have any allergies? ☐ Yes ☐ No

If yes, please explain.

Allergy: _____ Reaction Type: _____

Severity (*Scale of 1-10*): _____

reactive
PEDIATRIC
THERAPY LLC
Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

Is your child seen by a specialist?

Specialist	Name	Reason
Allergist		
Audiologist		
Cardiologist		
Developmental Medicine		
Endocrinologist		
ENT		
Gastroenterologist		
Geneticist		
General Surgeon		
Hand Surgeon		
Internal Medicine		
Nephrologist		
Neurosurgeon		
Neurologist		
OBGYN		
Oncologist		
Ophthalmologist		
Orthopedic Surgeon		
Pediatrician		
Psychiatrist		
Podiatrist		
Rheumatologist		
Thoracic Surgeon		
Urologist		

Has your child previously or currently received any therapy services? (OT, PT, ST, ABA, etc.)

Therapy	Frequency of Visits	Dates of Services	Clinician
Assistive Technology			
Audiology			
Behavior therapy			
Intensive Suit Therapy			
Developmental History			
Nutrition			
Occupational therapy			

reactive
PEDIATRIC
THERAPY LLC
Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

Physical therapy			
Social therapy			
Speech/ language therapy			
Vision therapy			

Developmental History

Milestone	**When *(in months)***	**Milestone**	**When *(in months)***
Creeps/ Crawls Alone		Rolls over	
Grabs toys		Sits alone without support	
Holds head up alone		Walks unaided	
Pulls self to standing position			

What do you hope to gain from your child receiving therapy at Reactive Pediatric Therapy LLC?

_____

_____

_____

_____

_____

_____

PARENT CONSENT TO TREAT CHILD IN SCHOOL FORM

I, _____, as parent / legal guardian hereby give permission for my son/daughter to receive therapy in the setting of their Daycare or School by their therapist at Reactive Pediatric Therapy LLC.

Please complete the following information:

Child's Information:

reactive
PEDIATRIC
THERAPY LLC

Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

Name: _____DOB: _____ Age: _____

School or Daycare Information:

Name: _____

Address: _____

Phone Number: _____ Teacher Name: _____

Parent/Guardian's Signature: _____ Date: _____

PATIENT HOME HEALTH SERVICES / OUTPATIENTS SETTING ATTESTATION FORM

I hereby certify that I am not currently receiving any home health services or outpatient services for the following (Occupational Therapy, Speech Therapy, Physical Therapy) nor am I currently under a home health plan of care with another center. If I receive other services, I will notify Reactive Pediatric Therapy LLC. If I should come under the care of a home health agency or outpatient setting with another center different from Reactive Pediatric Therapy LLC, I understand that I must notify Reactive Pediatric Therapy LLC immediately so that my treatment can be transferred or coordinated with my home health agency or outpatient setting.

Parent/Guardian's Signature: _____ Date: _____

HIPPA CONSENT FOR TREATMENT/ PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my child's protected health information by Reactive Pediatric Therapy LLC for the purpose of diagnosing or providing treatment to my child, obtaining payment for my child's health care bills or to conduct health care operations of Reactive Pediatric Therapy LLC. I have the right to revoke this consent, in writing, at any time, except to the extent that Reactive Pediatric Therapy LLC. has acted in reliance on this consent.

My child's "protected health information" means health information, including demographic information collected from me and received by my physician, another health care provider, a

reactive
PEDIATRIC
THERAPY LLC
Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

health plan, my employer, or a health care clearinghouse. This protected health information relates to my/my child's past, present or future physical or mental health or condition and identifies me/my child, or there is a reasonable basis to believe the information may identify me/my child. Reactive Pediatric Therapy LLC has an established privacy policy which is displayed in this office, and I can request a printed copy of this policy. I, the undersigned, a patient in Reactive Pediatric Therapy LLC and the subject of this authorization, hereby authorizes the professional staff of the above stated facility to administer treatment. I have been informed of the nature and purpose of treatment, common side effects thereof, alternative treatment modalities, approximate length of care, and that consent can be revoked orally or in writing prior to, or during the treatment period.

Patient Name: _____ Parent/Guardian's Signature: _____

CANCELLATION POLICY

If therapy needs to be cancelled the office should contact: _____ (name)

at _____ (phone number).

We understand that your child or family members may become ill, have other appointments, or emergencies at times. However, we ask that you make the effort to keep scheduled therapy appointments for the benefit of your child except for illness. If the therapist arrives at your home and no one is home, or the appointment is canceled within **1 hour** of the scheduled appointment time this will be considered a **"no show**." If two sessions are missed due to **"no shows"** or repeated cancellations within a 1-month period, **therapy will be discontinued**.

Please sign below that you have read and agree to our cancellation policy.

Parent/ Guardian Signature: _____ Date: _____

PHOTOGRAPHY/VIDEO RELEASE

reactive
PEDIATRIC
THERAPY LLC
Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

I permit Reactive Pediatric Therapy LLC to photograph or video any session of my child and these materials publicly to advertise Reactive Pediatric Therapy LLC. I understand that images and/or videos may be used on the Reactive Pediatric Therapy LLC social media outlets and in print or online publications. I also understand that no fee or other compensation shall become payable to me for participating in this release.

_____ I consent _____ I do not consent

Patient Name: _____

Parent/Guardian's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES USES AND DISCLOSURES OF HEALTH INFORMATION

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We may use or disclose the identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and provide you with a copy. Collection, Storage, and Destruction We keep all health information for six years after the case has closed. Health information is kept within a locked building, in a locked office, and stored within a locked filing cabinet. After six years, we will destroy the information by shredding and disposing of it. Individual Rights In most cases, you have the right to look at or get a copy of health information about your child. If you request copies, we will charge $.05 (5 cents) for each page. You also have the right to receive a list of instances where we have disclosed health care

reactive
PEDIATRIC
THERAPY LLC
Office: (954) 408-5710 Fax: (786) 408-5780
admin@reactivepedstherapy.com

information about you for reasons other than treatment, payment, or other related purposes. If you believe that information in your record is incorrect or missing, you have the right to request that we correct what is on file. You may request in writing that we do not use or disclose your information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. Complaints You may contact us at any time if you are concerned whether we have violated your privacy rights, or you disagree with a decision that we made about your records. You may also send a written complaint to the U.S. Department of Health and Human Services. Our legal duty We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact the office manager for the development, implementation, and oversight of the policies and procedures pertaining to HIPAA.

Parent/Guardian's Signature: _____ Date: _____