365 South Industrial Boulevard
Calhoun, GA 30701
Phone: (706) 624-3000
Fax: (706) 624-3001

ADVANCE for kids
PEDIATRIC
Physical, Occupational, and Speech-Language Therapy

212 West 3rd Street
Rome, GA 30165
Phone: (706) 295-4242
Fax: (706) 295-4260

A Neurodevelopmental Center

Child's Name: _____ Birthdate: _____ Age: ____ SS#:_____

Sex: ☐ M ☐ F Address: _____ City: _____ State: _____

Zip: _____ Primary Phone #: _____ Alternate Phone #:_____

Email: _____ Emergency Contact: _____ Phone #: _____

Diagnosis/ Reason of Referral: _____ Pediatrician/Primary Physician: _____

Insurance

List ALL INSURANCES even if services are not covered or we are out of network:

Primary Insurance: _____

Secondary Insurance: _____

Other: _____

Family Information

Mother/caregiver name: _____

Father/caregiver name: _____

Please list ***all other members currently living*** in household:

Name	Age	Relationship to patient	Any disabilities/deficits

Mother/caregiver occupation: _____

Father/caregiver occupation: _____

Marital Status of parents/caregivers: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Primary language spoken in the home: ☐ English ☐ Spanish ☐ Other _____

Pregnancy/Birth Information

List any complications during pregnancy (including accidents, high blood pressure, required medication, etc.):

_____

_____

Was tobacco, alcohol, or drugs used during the pregnancy? ☐ yes ☐ no If yes, please describe_____

_____

List any complications during the birth process (including if delivery was breeched, C -section, if forceps were necessary, prematurity, etc.) _____

_____

_____

Birth weight: _____lb. _____oz. If premature, how many day/weeks? _____

Did the baby spend time in the Neonatal Intensive Care Unit (NICU)? ☐ yes ☐ no How long?_____

List any complications noted after birth (including need for oxygen, jaundice, deformities, feeding difficulties, etc.)

_____

_____

Did the baby require an extended hospital stay after birth? ☐ yes ☐ no If yes, how long?_____

Medical/Health Information

Name of current medications, dosage, and reason for taking medication

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1) _____
2) _____
3) _____
4) _____

Please check all conditions your child has experienced:

☐ Adenoidectomy	☐ Ear Surgery	☐ Snoring
☐ Asthma	☐ Ear Tubes	☐ Tonsillectomy
☐ Breaths with mouth open during day/ night	☐ Frequent fevers	☐ Tracheotomy
☐ Bronchitis	☐ Frequent colds	☐ Meningitis
☐ Bronchopulmonary dysplasia	☐ Frequent pneumonia	☐ Mumps
☐ Cerebral Hemorrhage	☐ Frequent sinus infections	☐ Myelomeningocele
☐ Cleft lip or palate	☐ Head injury	☐ Reflux
☐ Coughing/choking during feeding	☐ Heart problems	☐ Seizures
☐ Craniofacial deformities	☐ Hoarse voice	☐ Soft Voice
☐ Ear Infections	☐ Loud Voice	☐ Vocal Nodules

List all significant illnesses, hospitalizations, and/or procedures with ***dates and locations*** (including surgery, MRI, swallow study, and other special testing)

1) _____
2) _____
3) _____

Other medical problems (allergies, precautions): _____
_____
_____

Has the child received therapy previously? ☐ yes ☐ no If yes, please list:

	Type of therapy (OT, PT, ST)	**Year**	**Location/facility**
1)			
2)			
3)			

What school/daycare does child participated in? _____

List any other concerns or comments: _____
_____
_____
_____
_____

******DOES YOUR CHILD HAVE AN IEP ☐ IEP (from school) ☐ IFSP (from Babies Can't Wait)**
If YES, Advance for Kids MUST have a copy for insurance purposes

_____ _____ _____
Signature of parent or legal guardian **Relationship to child** **Date**

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Conditions of Admission

Authorization for Treatment

I, the undersigned, hereby authorize and consent to rehabilitation services provided by Advance Rehabilitation for Kids, Inc. including any procedures which may be performed during this visit
for:_____ (Patient Name)

Assignment of Insurance Benefits and Release of Information

I hereby assign and authorize direct payment to Advance Rehabilitation for Kids, Inc. of all insurance benefits payable to me under the terms of any insurance policy for the services rendered, but not to exceed the regular charge for services received. I authorize any holder of medical information about me or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payor, and managed care organization or to any other insurance carrier, including worker's compensation claims. I authorize a copy of the authorization to be used in place of the original.

Medicaid Authorization and Assignment

I request that payment of authorized Medicaid, Medigap or other Medical Assistance programs be made on my behalf to the above provider for services furnished to me by the provider/supplier. I authorize any holder of medical information about me or any information needed to determine benefits payable to be released to my insurance carrier. My signature certifies that I have received a service beginning with the date below. I understand that payment for this service will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Law.

Personal Valuables

It is understood and agreed that Advance Rehabilitation for Kids, Inc. is not responsible for loss or damage to any personal valuables or properties.

Dependents/Visitors

In order to maximize safety, children other than the patient will not be allowed in the treatment area of the clinic. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of other children.

Financial Agreement, Guarantee of Account

I, the undersigned agree whether I sign as parent, guardian, spouse, agent, guarantor or as patient, that in consideration of the services to be rendered to the patient , I hereby individually obligate myself to pay the account of Advance Rehabilitation for Kids, Inc. in accordance with the regular rates and terms of the Facility.
I understand that therapy services are rendered and charged to the patient and not to the insurance company, and the facility cannot accept total responsibility for collection of claims nor for negotiating a disputed settlement.
I agree to be responsible for all deductibles, coinsurance and non-covered portions of services performed.
I understand that Advance Rehabilitation for Kids, Inc. is not a party to any lawsuit I may have due to litigation. I further understand that although information will be provided to my attorney, I am fully responsible to the provider for payment in full under the regular terms of the practice.

Should the account be referred to a collection agency or attorney for collection, I shall pay actual attorney's fees and collection expense.

I CERTIFY THAT I UNDERSTAND THIS FORM AND ACCEPT ITS TERMS

_____ _____ _____

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

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Patient Authorization Medical Records Release
Provider to Provider Communication

Patient Name: _____
Social Security Number: _____ **Date of Birth:** _____

I hereby acknowledge that Advance for Kids may use and/or obtain my health information for the purposes of treatment, payment, or other healthcare operations. I also hereby authorize Advance for Kids to use and/or disclose any of my health information related to my current diagnosis, illness and/or injury to individuals and/or groups of individuals listed below. The health information that I authorize to be used and/or disclosed is that information acquired during my care with Advance for Kids and any health information that pertains to my care including past medical history and previous dates of service and those services received up to my discharge from Advance for Kids.

Names of Individuals or Groups of Individuals I authorize Advance for Kids to disclose my health information and/or consent for Provider to Provider communication (physicians, schools, other professionals) to:

_____
_____
_____
_____

In order to provide continued outpatient services the following is requested:

☐ Occupational therapy ☐ Physical therapy ☐ Speech therapy
☐ Evaluations (Dates) _____ to _____
☐ Plans of care (Dates) _____ to _____
☐ IEP (Dates) _____
☐ Psychological Evaluation (Dates) _____
☐ Other _____

By providing this authorization, I understand as follows:

I understand that this authorization is voluntary. I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected.

1. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
2. I understand that I may revoke this authorization at any time by notifying Advance for Kids in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
3. I understand that I can receive a copy of this authorization form after I sign, at my request.
4. I understand that the Notice of Privacy Practices is posted in the clinic for my review. I also understand that a copy of the Notice is available to me, at my request.
5. I understand that this authorization will expire one year from the date it is signed or upon discharge of the patient.

_____ _____
Signature of Parent/ Legal Guardian **Date**

_____
Relationship to Patient

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Evaluation Checklist

To better serve all our clients we have implemented several policies regarding attendance and treatment. We attempt to be on time for your child's appointment as we do all our clients. Please remember that each therapist is scheduled for other appointments right before and after your child's appointment. Please initial on the box next to each paragraph/ service that your child will receive.

☐ **Policy for parents staying in the treatment session:** Parents are always welcome to stay during their child's treatment session. The best plan of action will be decided between you and the therapist. Please **do not** bring siblings back into the treatment area as this is a liability for the clinic.

☐ **Policy for length of session:**

☐ **Occupational Therapy and Physical Therapy:** Session will be approximately 25 or 55 minutes.
☐ **Speech Therapy:** Session will be approximately 25, 40, or 55 minutes.
☐ We allow 5 minutes at the end of each session to discuss treatment and progress with our parents. Not arriving on time to pick up your child will eliminate the time to discuss your child's treatment. If you would like to talk to your therapist for longer, please do so at the beginning of the session to ensure you have enough time.

☐ **Policy for attendance:** We ask a 24 hour notice for all cancellations and failure to provide notification will be considered a NO SHOW. Two "no shows" or cancellations can result in a reduction of services for your child and/or discharge. Please attempt to re-schedule your appointment if you should need to cancel. Being tardy for an appointment will directly affect the amount of time your child is seen. (For example, your child should have a 55 minute session and you are 10 minutes late. He/she will then have a 45 minute treatment session).

☐ **Policy on toileting:** If your child is not fully potty trained or wears diapers/pull-ups, we ask that you bring a change of clothes and diapers for accidents. We do not stock these items. We are unable to dispose of used diapers and will provide bags to carry soiled clothes or diapers home.

☐ **Policy on infection control:** Please be aware of your child's health and any possible illnesses that may be contagious. If your child has any of the following or any other transferable illnesses, please re-schedule your appointment:

- Fever 100° or above
- Measles
- Vomiting
- RSV
- Strep Throat
- Chicken Pox
- Impetigo
- Flu
- Conjunctivitis/pink eye
- Diarrhea due to virus
- Lice-(can return to therapy 24 hours after shampoo treatment)
- Ringworm-can return to therapy 24 hours after ointment and must be covered during treatment

Patient Printed Name: _____

Signature of Parent/ Legal Guardian: _____ _____
Date

Relationship to Patient: _____

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Picture Permission

I give permission to Advance Rehabilitation for Kids, Inc. to use pictures of my child, _____, in the following manner:

Please check all that you allow:

☐ Picture hung up in our lobby
☐ Picture in our advertisements (including website, printed material, display boards)
☐ Picture on social media including Facebook or Instagram

☐ I DO NOT WISH TO PARTICIPATE

_____ _____
Parent's Signature **Date**

Babies Can't Wait Waiver
(only for children under 3 years of age)

Babies Can't Wait (BCW) is a government funded program that encourages therapy in the home or other natural environments. By signing this form, you are stating that you were informed of this program but prefer _____ (child's name) to be treated in the clinic at Advance Rehabilitation for Kids.

_____ _____
Parent/ Legal Guardian Signature **Date**

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Privacy Notice: Written Acknowledgement Form

Our **"Notice of Privacy Practices"** provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I, _____, have reviewed the Advance Rehabilitation for Kids, Inc. **"Notice of Privacy Practices"**.

I understand that I may request a written copy of the notice at any time and that I may also ask questions to the representatives of Advance Rehabilitation for Kids, Inc. if I do not understand any information contained in the **"Notice of Privacy Practices"**.

_____
Patient Printed Name

_____
Signature of Authorized Representative of Patient

_____
Relationship to Patient

_____
Date