7209 Creedmoor Rd. Suite 101
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Office 919.844.1100 • Fax 919.844.1102
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www.PediatricPossibilities.com

Pediatric POSSIBILITIES, P.A.
"Making it Possible"

211 West Matthews St. Suite 106
Matthews, NC 28105
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**Download and save this file to your computer before filling it out.**

# Patient Information

Date:_____

Patient's Name:_____Patient's S.S.#_____
Date of Birth:_____ Age:_____Gender: ☐ M or ☐ F

Person completing this form:_____Relation to patient_____

Parent 1 Name: _____ Parent 2 Name:_____
Address: _____ Address:_____
City/State/Zip: _____ City/State/Zip: _____
Phone: (H) _____Phone: (H) _____
(W) _____(C)_____ (W) _____(C)_____
Occupation:_____Occupation:_____
Employer: _____Employer: _____
Fax Number_____ Fax Number_____
Email:_____ Email:_____

Best time, place and person to contact: _____
With whom does the patient live with? _____
Ages and genders of siblings:_____
_____

Person responsible for the bill: _____Relation to patient_____
S.S.# _____ Date of Birth: _____
Address: _____
City/State/Zip: _____
Health Insurance Company: _____Policy number:_____

Primary Physician: _____Phone: _____
Address: _____City/State/Zip: _____

Who referred the patient for services?_____

Reasons for the referral/visit/concerns you would like to share: _____
_____
_____

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# Infant and Early Toddler History

Today's Date:

Patient's Name: Date of Birth:
Person completing this form: Relationship:
Daycare/Preschool Attending (provide frequency):

**Additional space is provided at the end of the document.**

**Child's Developmental and Medical History:**

1. Please describe any pregnancy complications (diabetes, high blood pressure, hemorrhages, bed rest, full term, premature, multiple birth, etc...).

2. If adopted, at what age was your child adopted?
   Please include any other known information pertinent to the adoption.

3. Birth Information:
   Type: ☐ Vaginal ☐ C-section ☐ Emergency C-section due to:
   Instruments used:
   Medications used:
   APGAR Score: due to:
   Weight:

3. Hospital Stay:
   Uncomplicated, released in 48 hours: ☐ Yes ☐ No
   NICU Stay: days Due to:

   Did he/she experience Jaundice? ☐ Yes ☐ No Bilirubin light needed? ☐ Yes ☐ No

4. Early Feeding:

☐ Breast Feeding ☐ Bottle with breast milk ☐ Bottle with formula

Type of formula:

Did your baby latch to the breast or bottle immediately?

If no, what difficulties were encountered?

Did your baby gain weight at the recommended 4-8 oz. per week? ☐ Yes ☐ No

Were doctors concerned about your baby's low weight?

Was your baby diagnosed with reflux: ☐ Yes ☐ No

If Yes what treatment was provided?

5. Temperament:

Describe your child's behavior (passive, fussy, colic, etc..):

6. Hearing/Vision:

Did your baby pass the newborn hearing screen? ☐ Yes ☐ No

Do you have concerns about child's ability to hear (does not turn when name is called after 4 months of age, etc....) Please describe:

Does your child have a history of ear infections? ☐ Yes ☐ No

If yes, please describe the frequency of the occurrence and how the ear infections have been treated medically.

Does your child follow toys or your face with their eyes (after 4 months of age)?

8. Please give approximate ages that your child accomplished the following developmental motor milestones:

| | | |
|---|---|---|
| Rolled | Sat alone | Creep (4 point reciprocal crawling) |
| Cruised | Walked | |

Describe how your child crawled (on their tummy, on hands and knees) and for how long :

Describe if your child had any difficulty achieving motor milestones:

9. Please list pertinent medical history/surgeries:

10. Does your child have any medical or school related diagnosis? ☐ Yes ☐ No

If yes, who made the diagnosis?

When was the diagnosis made?

11. Does your child have any allergies? If yes, please list what your child is allergic to and how these allergies are medically managed and any behaviors your child exhibits that you think are related either to the allergies or the allergy medications.

12. Does your child currently take any medications? If yes, please list the medication, and for what condition the medication is taken. Please list any behaviors your child exhibits that you believe might be attributed to the medications.

13. Communication:

Describe how your child communicates hunger (hands in mouth, rooting, etc.)

Describe how your child communicates tiredness (nuzzling, rubbing eyes, etc.)

List some vocalizations and words your child uses (ga,bbb, aaa---oo, mama, da, etc.)

Does your child point to items of interest or things they want?

## ***Daily Routines:***

1. Meal Time:

How often does your child feed/eat?

Does your child eat baby food? ☐ Yes ☐ No How much per day?

Does your child eat solid foods? ☐ Yes ☐ No

☐ Fed by an adult or sibling OR ☐ Eat with fingers

2. Bathing:

Does your child enjoy bath time?

Does your child protest/show signs of distress when being washed?

When washing the hair, do you tilt the child backward to wet the hair or perform the task with the child sitting?

Does the child show signs of distress when tilted backward in the tub?

3. Hygiene

Do you brush their teeth/rub the gums?

Does your child shows signs of distress when the brush is in their mouth?

4. Bed Time: Please describe your child's bed time routine.

Where does the child sleep?
Does a parent sleep with the child?
When is the child put to bed for the evening?
How long does it take for the child to fall asleep?
Does the child sleep through the night?
What is the order of events prior to the child being put to bed for the night?

5. Sleep: Please describe how your child sleeps: easy to go to bed, hard to go bed, wakes during the night, hard to wake in the morning, wake up time)

6. Please describe how your child makes transitions between people or environments (separation anxiety, does not notice, etc...)

## ***Play/Social Skills***

1. Tummy Time

How often does/or did your child engage in tummy time?

What was your child's response to being put on their tummy?

Did your child develop a flat spot on the back of their head?

2. Describe what your child's play activities (swing, bouncer, bumbo seat, stuffed animals, chewy toys, etc....)

3. Does your child catch your gaze or make eye contact when playing with you?

4.Does your child mirror you when you laugh and smile?

5.Does your child show interest in novel toys presented or continue playing with previous toy?

## ***Parent Perspective***

1. What are your concerns about your child?

2. What do you hope to gain/achieve by attending occupational therapy?

3. Is there any additional information you would like to share?

**Please remember that consistent attendance and follow through with home activities is the key to helping your child be successful.**

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# Our Financial Policy

**Please review this document. You will be asked to sign at the first visit.**

**PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE**
The adult accompanying a minor at the time of service is responsible for full payment.

**No show fee**- Appointments that are missed without a 24-hour advance notice will be billed a $50.00 no show fee which will need to be paid at the following appointment. This fee is not billable to insurance.

## What if I have Insurance?

- Payment is still due at the time of your appointment.
- Pediatric Possibilities is an out-of-network provider. As the policy holder, you are responsible to know the benefits of your plan, such as reimbursement rate and how many visits are allowed per policy year.
- Once you know the specific benefits of your plan, we can assist with filing claims to your insurance company if applicable. This is a courtesy service that Pediatric Possibilities provides, and is not a guarantee of insurance payment. You should expect to receive an Explanation of Benefits summary from your insurance company itemizing each claim.
- Pediatric Possibilities is a Medicaid provider. We need a copy of your Medicaid card along with any other health insurance information *prior to* receiving services. We also need a copy of your Medicaid card monthly thereafter. If services are denied by Medicaid, you will be responsible for payment of therapy services.

I understand that it is my responsibility to know the details of my insurance coverage, and keep the office appraised of any insurance changes.

**Services and Fees**:

**Evaluation Fee:** $300.00 *Evaluation includes record review, one hour with therapist for evaluation, and a written report. If additional time with therapist is needed it will be billed at the treatment rate.*

**Treatment: Fee:** $140.00 **per hour**, $105.00 for 45 minutes, and $70.00 for 30 minutes

**Parent Conference Fee:** $140.00 **per hour**, $105.00 for 45 minutes, and $70.00 for 30 minutes
*Please note that the parent conference is not billable to insurance.*

I understand that I am responsible to pay for services rendered.

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# Attendance Policy

Pediatric Possibilities requires 24-hour notice to cancel or reschedule an appointment. Pediatric Possibilities has an attendance policy to monitor and ensure that clients regularly attend their scheduled appointments for an overall successful therapy program.

**Missed Appointment and Late Cancellation Policy**

A Missed Appointment or Late Cancellation (an appointment not canceled 24 hours prior to the appointment time) will result in a fee of $50*. Exceptions are made for emergencies and sudden illness.

Pediatric Possibilities understands there may be a Missed Appointment or Late Cancellation due to unforeseen circumstances or a scheduling conflict beyond your control. For this reason, we will waive your *first* Missed Appointment or Late Cancellation fee and will send you a reminder letter of the Attendance Policy.

A *second* Missed Appointment or Late Cancellation will result in a fee of $50*. This fee is the sole responsibility of the client and must be paid prior to your next scheduled appointment.

**Late Arrival Policy**

Clients arriving 15 minutes or later for their scheduled appointment will be charged the full treatment rate*. Pediatric Possibilities is unable to bill your insurance policy for any time missed due to late arrival to a scheduled appointment. Your Explanation of Benefits will reflect the amount billed to insurance.

Three (3) or more consecutive late arrivals may result in a scheduling modification to your recurring appointment. This will be discussed with you prior to change in scheduling.

**Repeated Missed Appointments or Late Cancellations Policy**

Missed appointments interfere with the client's plan of care and does not allow for others to receive care. Three (3) or more consecutive missed appointments may result in either forfeiture of your recurring scheduled appointment time or termination of service. This will be discussed with you prior to change in scheduling.

**Fee does not apply to clients who have Medicaid.*

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# PATIENT NOTIFICATION OF PRIVACY POLICIES AND RIGHTS

**Please review this document. You will be asked to sign at the first visit.**

**This notice describes how medical information about you may be used and disclosed. As well as how you can access this information. Please review it carefully.**

Purpose: to document the disclosure of policies regarding the storage, use and sharing of confidential information that we are required by law to abide by. In addition to the general information provided, patients may request to review the Pediatric Possibilities Privacy Policy Procedure Manual.

1. Confidential information will be stored in a secure location away from public access.
2. All employees and any other parties who have access to or who will be sharing the confidential information must sign a confidentiality agreement.
3. All employees have access to and reviewed a copy of the Privacy Policy Procedure Manual.
4. Employees have access only to information required to complete their job responsibilities.
5. Therapists will only have access to other therapist's patient information when it is necessary to provide the best collaborative services to the patient.
6. Evaluations, therapy plans, progress reports and treatment notes are sent to Insurance companies, other pay sources, and referring physicians for the purposes of requesting doctor's orders, authorization for services, or to obtain reimbursement for services. Information may be sent via first class mail, email or fax with procedures in place to limit the likelihood of unauthorized access. This information will be sent one time and the date sent will be documented. If an additional request for the same information is made, the patient/guardian will be given the documents for submission.
7. Confidential Information is not shared with 3rd parties (with the exception of those within Pediatric Possibilities) without written approval from the patient or guardian.
8. Any employees requiring access to confidential information have signed a "Employee HIPAA Agreement" promising to follow procedures to guard confidentiality.
9. Giving photographs to the clinic is considered authorization for displaying the pictures in the waiting room or on the website.
10. Parent's can observe therapy in the therapy room or through the viewing window if available.
11. The Office Assistant serves as the Privacy Officer. If any client/guardian has concerns that confidentiality has been or is in danger of being breached, they are asked to report it to the Privacy Officer (reports will not be used against a client to change treatment plan). You may contact the Office at 919-844-1100.
12. All attempts should be made to hold conversations, which may include confidential information in a location away from public access.
13. All computers containing confidential information are only accessed via a password. Employees only have access to information critical for their job responsibilities.
14. By requesting or initiating e-mail communications, patients/guardians understand that Pediatric Possibilities email addresses are not encrypted, and agree to release Pediatric Possibilities and its employees for any breach of confidentiality that may occur with information transmitted over the internet.
15. Authorization is required by the client for uses and disclosures of protected health information for marketing purposes.
16. Individuals who pay out of pocket in full for healthcare or service have the right to restrict disclosures of protected health information to their health plan
17. Individuals will be notified in the unlikely event of a breach of unsecured protected health information.
18. In order to amend protected health information, the patient must make the request in writing and include the specific reason for requesting an amendment.

19. All requests for inspection and/or copies of clients protected health information must be made in writing and directed to our privacy officer. Electronic health records will be readily accessible and distributed to the client in a format mutually agreed upon by Pediatric Possibility staff and client. The request will be made in writing and client will incur a fee (.07 a page)
20. Other uses not described in the patient notification of privacy policies will be made only with authorization from the individuals to whom the protected health information relates.
21. Pediatric Possibilities reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that we maintain.

## Use and Disclosure of Your Protected Health Information and Consent for Treatment

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES PRESENTED IN THIS DOCUMENT.
I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICE FORM.
I CONSENT THE THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI) BY PEDIATRIC POSSIBILITIES FOR THE PURPOSE OF TREATMENT, PAYMENT AND GENRAL HELTHCARE OPERATIONS.

My consent is evidenced by my signature on this document.