Patient Information Form

Keystone Pediatric Therapy PLLC
2720 Virginia Parkway, Suite 300, McKinney TX 75071
(972) 548-1990

PATIENT INFORMATION:

Patient Name: _____ **Sex:** ☐Male ☐ Female
(Last) (First) (Middle)

Nickname: _____ **Child's Social Security #:** _____ **DOB:** _____

Parent/Legal Guardian: _____ **Relationship:** _____ **DOB:** _____

Parent/Legal Guardian: _____ **Relationship:** _____ **DOB:** _____

Address: _____
(Street) (City) (State) (Zip)

Email Address: _____ **Religion:** _____

***Race:** ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White
☐Hispanic or Latino ☐Native Hawaiian/Other Pacific Islander ☐Other

***Ethnicity: Hispanic/Latino or Alaska Native** ☐Yes ☐No **Language(s) Spoken in the Home**: _____

*Required by Title 25, Texas Administrative Code, Chapter 1301.19 ©(1-2)

Referred by: _____

Primary Care Physician: _____ **Phone#:** _____

Address: _____

Specialists involved in child's plan of care (neurologist, gastro-enterologist, developmental pediatrician, pulmonologist, etc.)

Name: _____ **Phone#:** _____

Address: _____

Name: _____ **Phone#:** _____

Address: _____

INSURANCE INFORMATION:

Primary Commercial Insurance (please bring card to visit)

Insured: _____ Social Security #: _____ Date of Birth: _____

Relationship to Child: _____ Home Phone: _____ Work Phone #: _____

Insurance Company: _____

Identification #: _____ Group #: _____

Employer: _____

Employer Address: _____
Street *City* *State* *Zip*

I understand that it is my responsibility to provide updated information to Keystone Pediatric Therapy on any changes in my child's medications and/or allergies. If I fail to provide this information in a timely manner, I hereby release Keystone Pediatric Therapy from and all liability on information that has become inaccurate.

_____ _____
**Parent/Guardian Signature Date

Patient Preference Regarding Communication of Health Information

I. How to Contact

I wish to be contacted in the following manner:

Home Telephone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Work Telephone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Cell Phone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Day Time Phone # _____
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

Written Communication:

[ ] OK to mail my home address _____
[ ] OK to mail to my work/office address _____
[ ] OK to fax to this number _____
[ ] OK to email (for appointment reminder only) to: _____

II. Who to Contact

I hereby give permission to Keystone Pediatric Therapy to disclose any information related to my child's therapy session(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship

[ ] **I do not wish to disclose information with anyone**

III. Permission to Release Child

Your child will not be released to any person(s) whose name does not appear on the form. NO verbal authorizations will be permitted. If names are to be added or deleted to this list, please do so in writing. The staff at Keystone Pediatric Therapy reserves the right to ask any individual to show proper identification. This is for the protection of your child(ren). I hereby give permission to Keystone Pediatric Therapy to release my child, in my absence, to the following list of people:

Same as above [ ] Yes [ ] No

Name	Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____

**Parent/Guardian Signature Date

HEALTH HISTORY:

Please check "YES" or "NO" for the following statements and complete the "Comments" section after the questions if needed

YES	NO	HEALTH
☐	☐	Child was born before due date; number of weeks premature: _____
☐	☐	Complications during pregnancy and/or after delivery
☐	☐	Child has reflux or history of reflux
☐	☐	Child experiences diarrhea frequently or is often constipated
☐	☐	Child has an extremely limited diet
☐	☐	Child has history of ear infections
☐	☐	Child has Pressure Equalization (PE) Tubes (how old when placed?_____)
☐	☐	Child has history of upper respiratory infections
☐	☐	Child has been treated for a metabolic disease
☐	☐	Child has frequent headaches
☐	☐	Child has sleep problems
☐	☐	Child has seizures or other neurological condition
☐	☐	Child has recent injury or regression; Date of injury:
☐	☐	Child is considered healthy

Comments: _____

_____

_____

_____

Does your child have any medical conditions related to the following:

Heart	☐No	☐Yes	Bone Joint Injuries	☐No	☐Yes	Cancer	☐No	
Lungs	☐No	☐Yes	Cytomegalovirus (CMV)	☐No	☐Yes	High Blood Pressure	☐No	
Kidneys	☐No	☐Yes	Seizure	☐No	☐Yes	Difficulty Eating	☐No	
Digestive System	☐No	☐Yes	Arthritis	☐No	☐Yes			
Surgery	☐No	☐Yes	Diabetes	☐No	☐Yes			

If yes, please explain: _____

Does your child have any other medical conditions, contagious or otherwise, that we should know about? ☐No ☐Yes

If yes, please explain: _____

Current Weight:_____ **Height:** _____ **Head Circumference:** _____

Has child had <u>unintentional</u> weight gain or loss of more than 5 pounds in the last 12 months? ? ☐No ☐Yes

Please check the tests below that your child has received or is scheduled for:

TEST	DATE TESTED	REASON FOR TESTING
☐Auditory Brain Stem Response		

☐Electroencephalogram (EEG) – Brain		
☐Vision Assessment at School		
☐Vision Assessment by Ophthalmologist		
☐Hearing Assessment		
☐ImmunoglobulinE (IgE) Allergy Test		
☐Food Intolerance Test- gluten,lactose,casein		
☐Magnetic Resonance Imaging (MRI)		
☐Genetic Screen		
☐Video Swallow Study		
☐Other:		

ALLERGIES:

Food / Environmental Allergies? Yes / No If yes, please list here or attach list.

_____

Medication Allergies? Yes / No If yes, please list here or attach list.

_____

CURRENT THERAPY AND EDUCATION INFORMATION:

What is your child's current educational level? _____

Average Grade: ☐A ☐ B ☐C ☐ D Name of School District: _____

Name of School: _____

☐Regular Classroom ☐ Resource Classroom ☐Self-Contained

What Services does your child receive at school? (Include Therapist name and provide Individualized Education Program (IEP) Reports)

Service	Therapist Name	Service	Therapist Name
☐Occupational Therapy		☐Speech Therapy	
☐Physical Therapy		☐Other	

Has your child received therapy services in the past year? ☐No ☐Yes If yes, When and Where? _____

_____

SURGERIES / PROCEDURES HOSPITALIZATIONS:

Date	Procedure	Physician / Hospital

Has your child ever been in "isolation" during a hospital stay? ☐No ☐Yes

If yes, please explain: _____

MEDICATION PROFILE (attach list if necessary):

Medication Name	Dose	Frequency

DEVELOPMENTAL HISTORY:

At what ages were the following developmental milestones attained?

Sat at _____ months	Crawled on hands & knees at _____ months	Rode Bicycle without training wheels _____ years
Walked at _____ months	Said 1st meaningful word at _____ months	Completed toilet training at _____ years

What are your concerns regarding your child's abilities? Please be specific as to skills you would like your child to attain as well as differences or difficulties your child is experiencing. (DO NOT LEAVE BLANK)

COMMUNICABLE DISEASE / IMMUNIZATION SCREEN:

Are your child's immunizations up-to-date? ☐Yes ☐No If "No", please contact your primary care physician.

In addition, we need for you to understand that the health and safety of all children and staff must be protected, so please be aware of the following: **YOUR CHILD MAY NOT VISIT OR RECEIVE TREATMENT IF THE CHILD HAS ANY OF THE DISEASES / SYMPTOMS LISTED BELOW. THESE DISEASES COULD BE HARMFUL TO THE CHILDREN WHO RECEIVE TREATMENT AT KEYSTONE PEDIATRIC THERAPY PLLC. PLEASE LET THE STAFF KNOW IF YOUR CHILD IS EXPOSED TO OR BECOMES ILL WITH ANY OF DISEASES/SYMPTOMS LISTED BELOW.** **Initial Here _____**

Has your child been exposed to ANY of these communicable diseases or had any of the symptoms TODAY or IN THE LAST 24 HOURS?

Diarrhea, Nausea, Vomiting	☐No	☐Yes	Cold Sores	☐No	☐Yes
Fever, Cough	☐No	☐Yes	Impetigo	☐No	☐Yes
Running Nose, Sore Throat	☐No	☐Yes	Infected or Draining Sores	☐No	☐Yes
Measles, Mumps, Chicken Pox	☐No	☐Yes	Rash from Unknown Cause	☐No	☐Yes
MRSA (methicillin-resistant staphylococcus aurea)	☐No	☐Yes	Pink Eye	☐No	☐Yes
Tuberculosis	☐No	☐Yes	Night Sweats, Fever, Weight Loss, Coughing up blood	☐No	☐Yes

By signing below, I certify that I have answered all questions with accurate and complete information. I understand that it is my responsibility to promptly notify Keystone Pediatric Therapy if I discover any information is or becomes inaccurate or incomplete. I hereby release Keystone Pediatric Therapy from all liability for any action based on inaccurate or incomplete information both now and in the future that I have failed to notify Keystone Pediatric Therapy about.

_____ _____ _____

***** Parent or Guardian Signature*** ***Date*** ***Time***

_____ _____ _____ _____

Staff Signature ***Initials*** ***Date*** ***Time***

Keystone
Pediatric Therapy

Parental Consent for Treatment

I hereby authorize employees and agents; including physicians and therapists of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' / therapists' choice.

I consent for:

Child's Name: _____ DOB: _____/_____/_____ Male Female
To authorize evaluation and treatment for my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical procedures for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

_____

Signature of Parent or Legal Guardian **Date**

Please print name: _____

Keystone
Pediatric Therapy

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations – *HIPPA*

I, (Parent/Guardian) _____, understand that as part of my child's

(Name) _____ DOB: _____ healthcare,

Keystone Pediatric Therapy originates and maintains paper and/or electronic records describing their health History, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment;
- A means of communication among the many health care professionals who contribute to my child's care;
- A source of information for applying my child's diagnosis and treatment information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Information and Privacy Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges listed below:

- The right to review the ***Notice of Information and Privacy Practices*** prior to signing this consent.
- The right to object to the use of my child's health information for directory purposes, and
- The right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I wish to have the following restrictions to the use or disclosure of my child's health information:

_____

_____

I understand that Keystone Pediatric therapy is not required to agree to the restrictions that I request, and can legally refuse the restriction request if it involves the safety or well-being of my child. I understand that I may revoke this consent to Keystone Pediatric Therapy in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that my refusing to sign this consent or revoking this consent, this organization may refuse to treat my child as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Keystone Pediatric Therapy reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Keystone Pediatric Therapy change their notice, they will send me a copy of any revised notice to the address I've provided (whether US Mail, or if I agree, email).

I understand that as a part of the organization's treatment, payment, or health care operations, it may become necessary to disclose my child's protected health information to another entity, and I consent to such disclose for these permitted uses, including disclosure via fax.

Acknowledgement of Receipt of Notice of Privacy Practices

I fully understand and accept / decline the terms of this consent.

_____ _____

Parent/Guardians Name Parent/Guardian Printed Name

_____ _____

Relationship to Patient Date

Keystone Pediatric Therapy – Policies and Procedures

Keystone Pediatric Therapy Services: Keystone Pediatric Therapy offers speech and occupational therapies. All therapists at Keystone are licensed professionals with special training & interest in treating children.

Attendance:

- At least 80% attendance of scheduled visits is required of all patients.
- You must call our office at 972-548-1990 or text 972-696-9043 to cancel 24 hours prior to a scheduled appointment or a cancellation fee may be charged. We realize cancellations will occur due to sickness, weather, and vacations. If a family vacation is being planned, those dates need to be given to the office staff in advance in order to avoid a cancellation fee. If your child has a communicable disease that prevents him/her from attending, a cancellation may be excused if proper documentation is presented. We will work with families for medical leave or insurance issues.
- If you "no show", or miss 2 appointments without calling to cancel, your child will be taken off of the regular schedule and you will have to call and make individual appointments week-by-week. If you miss 3 appointments without calling to cancel, your child will be discharged from therapy services. A letter will be sent to you confirming the discharge.
- You are strongly encouraged to reschedule cancelled appointments so your child can receive full benefit from therapy. In the event your primary therapist is out, we will attempt to provide coverage with a secondary therapist.

Inclement Weather: In cases of inclement weather, please follow the **McKinney ISD** school schedule. If the district is opening late or closed for the day, we will also open late or close accordingly. We follow the McKinney ISD schedule for inclement weather ONLY. We are open on Columbus Day, Martin Luther King Jr. Day, spring break, and teacher work days, etc.

Health/Safety: Please do not bring your child to therapy if they have had a fever within 24 hours of their appointment. For the safety of your child and other children, please keep your child/children with you at all times when they are not in their treatment sessions. For the safety of our patients with food allergies, there is NO EATING/DRINKING in the waiting room. Please be available to speak to the therapist approximately 5 minutes before the end of your child's therapy session. This will give your child's therapist an opportunity to discuss results of treatment and will insure that your child will not be left unaccompanied in the waiting area.

Progress Reviews: Specific to your child's developmental needs, therapists will be working with your child on identified goals and objectives, and modifying them during the entire course of treatment. You will be given a list of your child's goals and objectives, and invited to give feedback on them. Parent participation and involvement in the therapy process is encouraged. Some children do better with parents in the room, while others do better with parents outside of the therapy room for all or part of the treatment sessions(s). Space and confidentiality may also be an issue in some cases. Therapists and parents will work together to devise the best plan. Progress notes will be completed periodically when requested by your insurance provider or physician. Re-evaluations will be completed once yearly unless otherwise requested by your physician or insurance provider. Therapists may elect to complete a re-evaluation at the time of discharge or when he/she feels it is appropriate.

Discharge: Discharge is a natural part of one's treatment plan. There could be several reasons for your child's discharge from our services. These include: goals of therapy being met, transition to other services (primarily PPCD and other school-related services), functional progress plateau, insurance discontinued, poor attendance (80% or greater required), parent terminates.

Communication: Your child's progress is dependent on how well we (therapists and caregivers/ parents) work as a team to maximize their outcomes. This requires good communication between the therapists and the caregivers. In addition to the last 5 minutes of your child's therapy session, please select one of the following methods that would best meet your needs for communication with the therapists and office staff:

_____ Written communication _____ Email - _____

_____ Phone _____

_____ _____

Parent/Guardians Name Date