UNIFIED Therapy Services
4121 Pennsylvania Avenue • Dubuque, IA 52002 • Phone: 563.583.4003 • Fax: 563.265.5789

PATIENT HEALTH HISTORY INFORMATION -PLEASE PRINT CLEARLY

Please provide a copy of your insurance card(s) to our Front Desk Staff.

Name (Last) _____ (First) _____ (M.I) _____
Birth Date_____ **Sex:** ◯ M ◯ F **Language**_____ Will translation be needed?
Home Address _____**Apt/Unit**_____
City _____**State**_____ **Zip**_____

PARENT/GUARDIAN CONTACT INFORMATION:

Name_____ **Relation**_____
Address (if different than above) _____
Home Phone_____ **Cell Phone**_____
Place of Employment_____ **Work Phone**_____
Email_____

Name_____ **Relation**_____
Address (if different than above) _____
Home Phone_____ **Cell Phone**_____
Place of Employment_____ **Work Phone**_____
Email_____

Preferred primary contact: _____
Preferred method of contact: **May we leave a message?**
When possible, would you like to receive text or email reminders regarding your appointments times:

EMERGENCY CONTACT:

Name_____**Relation**_____
Address_____ **Phone**_____

HOW DID YOU HEAR ABOUT US? _____
Primary Care Physician_____ **Facility**_____
School_____ **Teacher and Grade** _____

Student Status:

IEP: - If the patient has an IEP, please provide us this document to scan into their chart.

A. Does the patient attend daycare? If yes, where? _____
B. If the patient attends daycare in Dubuque, would you be interested in UTS providing therapy at the daycare if the director agrees?
C. Does the patient receive services from any community/ home health agencies?
If answer to C is yes please list agency, supervisor and phone number.
_____
D. Please list concerns necessitating therapy services: _____
_____
E. Does the patient reside in an ICF-ID facility? If yes, where? _____

MEDCIAL HISTORY

A. **Patient Diagnosis (**please include all**):**

B. **Allergies**: Please include medication, food, and other:

C. Are you latex sensitive?

D. Does the patient have a history of seizures?

Unified Therapy Services' policy is that a parent/guardian/caregiver is to provide a written seizure protocol detailing specific instructions for staff to follow in the event of a seizure.

When having a seizure (what occurs?)

E. If a seizure occurs while receiving skilled services, I would like UTS Staff to: (please print)

In the event of a seizure, please call: ☐ Parent/Guardian ☐ Emergency Contact ☐ Other: _____

EMERGENCY MEDICAL SERVICES CONSENT

Preferred Hospital: _____

I request Unified Therapy Services to: (*Please specify below by checking ONE box only)*

☐ PROVIDE (RESUSCITATE REQUESTED) rescue breathing or CPR if I am in their care during a time of crisis

☐ DECLINE (DO NOT RESUSCITATE) or use rescue breathing or CPR if I am in their care during a time of crisis.

GENERAL INFORMATION

A. Is the patient on a special diet or do you consider him/her to be a selective eater? (If yes, describe)

_____

B. Has the patient ever received therapy services in the past? f yes, describe)

_____

C. Does the patient currently utilize any adaptive equipment to assist with completion of daily activities?
(If yes, describe) _____

   a. What durable medical equipment provider or orthotics/prosthetics company does the patient currently use? _____

D. Does the patient have equipment needs that are currently not met? (Wheelchair, braces, etc.)

E. Please list any pertinent medical, personal, or social information that you feel may contribute to the evaluation or treatment process: _____

F. If there was an injury or illness that caused a change in functioning level of the patient, please describe including date of onset and change in skill level: _____

G. If difficulties were identified at birth please indicate complications and outcomes:

MEDICATIONS:

Please list any medication currently being taken, the dosage, frequency, and intended usage and side effects.
If the child requires use of an epi pen for food or stings, has active Grand Mal Seizures, or low blood sugar requiring insulin the parent/guardian will be required to stay at UTS for the duration of appointments as our staff does not administer medications.

MEDICATION	DOSAGE	FREQUENCY	REASON	SIDE EFFECTS

PUBLIC RELEASE

Occasionally, Unified Therapy Services will photograph or videotape for educational and/or marketing purposes. We will always verbally discuss with the patient/parents/guardians before anything is printed for marketing purposes.

- ☐ I hereby give my permission to **ALLOW** photos/videos to be taken.
- ☐ I **DECLINE** the use of photos/videos to be taken.

MEDIA DISCLOSURE:

This disclosure is to inform you of Unified Therapy's policy for use of photography and videos within our facilities and to comply with HIPAA laws. Clients may be photographed or videotaped by their parents/caregivers. The therapist who is treating the client must be notified about the purpose of the video/photo. **If there is any potential for other clients to be viewed, then videotaping and/or taking pictures is prohibited.** The therapy sessions that are videotaped or photographed shall not be used for training purposes of the clients related to their plan of care. (Unless otherwise directed by the therapist). The services provided by Unified Therapy Services/Health Services are confidential and are protected under HIPAA. If these pictures or videos are utilized inappropriately once in the possession of the individual taking the video/photo, Unified Therapy shall not be held accountable.

OUTDOOR THERAPY (*please check one box below***)**

- ☐ I hereby give my permission to **ALLOW** outdoor therapy. Therapy services outdoors with full knowledge that he/she may be in the public's eye and could result in grass/dirt stains on clothing.
- ☐ I **DECLINE** the use of outdoor therapy.
- ☐ **Sunscreen permission:** In the event where _____ (child's name) is taken outdoors for a duration longer than 10 minutes during the months of May to October for a treatment session, I give my permission for Unified Therapy staff to apply sunscreen to protect my child's skin as acknowledged by my signature _____. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of ears, nose, bare shoulders, arms and legs.
  ***If your child is allergic to certain sunscreens please provide the sunscreen of your choice during these months. We will write their name on the product and keep in a safe place**.

BILLING/FINANCIAL

PRIMARY INSURANCE_____ PHONE NUMBER _____
INSURED'S NAME _____ INSURED'S DOB _____
POLICY#_____ GROUP#_____
DRIVER'S LICENSE #_____

SECONDARY INSURANCE_____ PHONE NUMBER _____
INSURED'S NAME _____ INSURED'S DOB _____
POLICY#_____ GROUP#_____

Please let our Billing Staff know if you have a Tertiary Insurance.

CONSENT FOR CARE/ASSIGNMENT OF BENEFITS/LIABILLITY WAIVER

I certify that the above noted insurance carriers or payment sources are complete and correct as written.

I authorize Unified Therapy Services to release information from my medical records as may be necessary for the completion of the clinic's claims for reimbursement to third party payers as needed for this or related claims. This authorization may include copies of my medical records to be sent to my insurance carrier.

In consideration of the services received or to be received by Unified Therapy services, I assign all insurance, Medicare, or Medicaid due me to Unified Therapy Services. I hereby agree to pay Unified Therapy Services any and all charges that exceed or that are not covered by my insurance coverage.

I APPROVE OF THE NOTED DIAGNOSTIC/REHABILITATIVE SERVICES.

Patient Signature_____ **Date**_____
Parent/Guardian Signature ***(If patient is a minor)*** _____ **Date**_____

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Pediatric Clinic • 563-583-4003

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Information Release Form

PATIENT NAME_____ **DOB**_____

PARENT(s) OR GUARDIAN(S) _____

ADDRESS_____**CITY**_____**STATE**____**ZIP**_____

PHONE (HOME) _____ **(WORK)** _____

EMAIL ADDRESS_____

I hereby give **Unified Therapy Services** permission to **receive and release all information** to/from the following individuals/groups/agencies/organizations regarding this patient. (**Please check all that apply)**

☐ Physician_____

☐ School_____

☐ Keystone AEA_____

☐ Head Start _____

☐ University of Iowa Hospitals & Clinics_____

☐ Community Services_____

☐ Department of Human Services_____

☐ Dubuque County Case Management_____

☐ MedicalVendors_____

☐ Parents as Teachers_____

☐ Jeannie Simms _____

☐ Compass Counseling _____

☐ Other_____

Authorized Signature_____ **Relationship to Patient**_____ **Date**_____

In the event we need to contact you, at what phone number can you be reached?

1. _____-_____-_____May we leave a message Whose #? _____
2. _____-_____-_____May we leave a message Whose #? _____
3. _____-_____-_____May we leave a message Whose #? _____

When leaving a message for you at any of the above listed numbers, is there information that you would **not want left** on the recorder? (For example: Name of our clinic, person calling, reason for call, patients name, appointment times, insurance information. etc.)

☐ **NO.** There are **No** restrictions. Any necessary information may be given to the person answering the phone or left on the answering machine or voicemail.

☐ **Yes**. There **ARE restrictions. Please specifically list all restrictions and instructions that apply when staff are trying to contact you.**

_____

I hereby authorize to have _____ (name of patient) released to the following individuals:

Name _____ Contact Number _____ Relationship _____

Name _____ Contact Number _____ Relationship _____

Name _____ Contact Number _____ Relationship _____

Authorized Signature _____ **Relationship to patient**_____ **Date**_____

WAIVER/RELEASE FOR COMMUNICABLE DISEASES INCLUDING COVID-19

ASSUMPTION OF RISK/WAIVER OF LIABILITY/INDEMNIFICATION AGREEMENT

In consideration of being allowed to participate in therapy and other clinic operations on behalf of Unified Therapy Services, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious diseases including COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and
3. I willingly agree to comply with the stated and customary terms and conditions for participation in therapy services and other clinic operations as regards protection against infectious diseases. If, however, I observe any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representative and next of kin, HEREBY RELEASE, DEFEND AND HOLD HARMLESS Unified Therapy Services and their employees used to conduct therapy services and clinic operations ("RELEASES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILLITY, DEATH, or loss or damage to person or property arising out of participation in therapy services or clinic operations, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND AND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Patient Signature: _____

Parent/Guardian Signature *(If patient is a minor)*: _____

Date signed: _____

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Pediatric Clinic • 563-583-4003

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HOURS OF OPERATION, HOLIDAYS AND WEATHER POLICY

Hours of Operation

Monday – Thursday	8:00 a.m. – 6:00 p.m.
Friday	8:00 a.m. – 12:30 p.m.
Saturday and Sunday	Closed

***If your child's appointments are during the school day, you may ask for an appointment confirmation letter from the Front Desk Coordinators to provide to your child's school.

Holidays

Unified Therapy Services is closed for the following holidays:

New Years Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
The Friday following Thanksgiving Day
Christmas Day

Please contact front desk to reschedule these appointments within the surrounding weeks.

Weather Policy

To ensure the safety of our patients and staff during inclement weather, UTS will follow these guidelines based on the Dubuque Community School District:

Dubuque Community School:	**Unified Therapy Services:**
Delayed	Normal Business Hours
Closure *	Opens at 10 a.m.
Dismiss Early	Normal Business Hours (unless notified)

* You will receive a text message from us and we ask that you reply back to reschedule, confirm or cancel the appointment.

UNIFIED THERAPY SERVICES ILLNESS GUIDELINES

In order to keep Unified Therapy Services' patients and staff in the healthiest environment possible, we are adopting/implementing the following illness guidelines. If the patient is ill, please call to reschedule their appointment for a different date/time during the week or ask for an additional therapy session the following week. We want our patients to receive the recommended amount of therapy, however, we also realize if someone is ill he/she will not be able to put forth his/her best effort or do we want clients who are immunocompromised to be exposed to illnesses.

Patients should **not** attend therapy sessions if:

1. They are not fever free for 24 hours. Any patient with a fever greater than 100.4 should not attend therapy sessions.

2. They have vomited from an illness in the last 12 hours.

3. They have had more than two diarrhea episodes in the last 12 hours.

4. They are experiencing constant nasal drainage and/or frequent coughing. Minor common cold symptoms should not interfere with therapy sessions.

If the illness requires medication, the patient must take the medication for the prescribed amount of time to no longer be considered contagious in order for the patient to return to therapy. (Ex. 24 hours before an antibiotic takes effect.)

In light of the recent developments with bed bugs and head lice, Unified Therapy Services is requesting that patient's complete the recommended number of treatments for exposures, before returning to therapy. If you suspect or know of head lice or exposure to bed bugs it is your responsibility to notify UTS immediately.

Thank you,

Unified Therapy Services

*Keep this sheet for your reference.

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UNIFIED THERAPY SERVICES PATIENT ATTENDANCE/TARDINESS POLICY

I understand that it is my responsibility to have _____attend all scheduled therapy appointments or to *call and cancel at least 2 hours in advance*. I further understand that messages may be left on the answering machine after hours and the staff of Unified Therapy Services (UTS) will receive these messages the following day.

I understand that if he/she does not attend the schedule appointment and if the staff of UTS then has to call me, this will be considered a **No Call/No Show (NC/NS)** visit.

I understand that the therapist (s) will **verbally discuss attendance policy** for the above named patient if he/she has 2 consecutive cancellations or 1 NC/NS.

I understand that the therapists (s) **will send a written notification for** the above named patient if he/she has 2 consecutive NC/NS, 3 consecutive cancellations, or if attendance is less than 60% for the given quarter.

I understand that the above named patient **may be discharged** from all therapy services if he/she has 3 consecutive NC/NS visits, 4 consecutive cancellations, or if frequency of attendance has not improved to greater than 60% by the end of the following quarter.

I understand there may be extended excused absences related to hospitalizations, surgery, injuries, illness, and intense therapy programs. or extended vacations.

I understand that any child age 12 and under must be accompanied to and from therapy until contact is made with a therapist.

I understand that if I am not accompanying the above named patient to therapy it is my responsibility to have her/him dropped off and picked up on time for all therapy appointments. I understand that if he/she is **tardy in excess of five times**, the therapist will verbally discuss the importance of timeliness.

I understand that if tardiness continues after the verbal discussion, the therapist and front desk personnel will make a change in the schedule (if available) in order to address the issue of tardiness.

I understand that if tardiness continues after a therapy time change, that the above named patient **may be discharged from therapy.**

I understand any exception will be at the discretion of Unified Therapy Services.

By signing below I indicate that I have read the above stated policy.

_____ _____

Patient/Caregiver Signature Date

_____ _____

Staff Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow–up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office use only

The following attempts were made to obtain patient/guardian signature in acknowledgement on this Notice of Privacy Practices Acknowledgement:

- ☐ Sent the Notice of Privacy Practices & Notice of Privacy Practices Acknowledgement with Self-Addressed Stamped return envelope. Date:_____
- ☐ Made a follow up call 4 – 5 days later. Date:_____
- ☐ Sent a copy home with patient. Date:_____
- ☐ Made a final follow up call. Date:_____

All the above-mentioned attempts were made to obtain the patient/guardian's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials:	Reason: