Phone: 563.583.4003 • Fax: 563.265.5789

Name:______________________________ **Birth Date:** ____________________

PARENT/GUARDIAN CONTACT INFORMATION:

Preferred Contact Name:____________________ Relation:____________________

Address:____

Cell Phone:____________________ Other Phone:____________________

E-mail address:____________________ Employer:____________________

Preferred method of contact: Call ☐ Text ☐ Email ☐ May we leave a message? Yes ☐ No ☐

Would you like to receive appointment reminders: Text ☐ Email ☐ None ☐

Secondary Contact Name:____________________ Relation:____________________

Address:____

Cell Phone:____________________ Other Phone:____________________

Email: ____

EMERGENCY CONTACT:

Name:______________________________ Relation:____________________

Phone: ______________________________

School:______________________________ Teacher and Grade:____________________

IEP: No ☐ Yes ☐ Please provide Front Desk with this document to scan into their chart.

A. Does the patient attend daycare? No ☐ Yes ☐ Where?____________________

B. If possible, would you be interested in UTS providing therapy at the daycare? Yes ☐ No ☐

C. Does the patient receive services from any community/ home health agencies? Yes ☐ No ☐

If yes: Agency:________________Supervisor:____________________Phone:________________

D. Please list concerns necessitating therapy services:

E. Does the patient reside in an ICF facility? No ☐ Yes ☐ Where? ____________________

F. Is the patient on a MR or ID waiver? No ☐ Yes ☐ Waiver name? ____________________

***If patient is on a waiver please see the front desk to discuss.**

MEDICAL HISTORY:

A. Patient Diagnosis (please include all):____

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

C. Is the patient latex sensitive? Yes ☐ No ☐

D. Does the patient have a history of seizures? Yes ☐ No ☐

- How does a seizure typically present for this patient?

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.

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 the patient is 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. Has the patient ever received therapy services in the past? No ☐ Yes ☐ Describe below:

B. Does the patient utilize any adaptive equipment to assist with completion of daily activities? Yes ☐ No ☐
Please describe: ____

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

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

E. 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:

F. Was the child carried to full-term pregnancy (at least 40 weeks)? If not, how many weeks were they carried to?

MEDICATIONS: Yes ☐ No ☐

Please list any medication currently being taken, dosage, frequency, intended usage and side effects.

****If the child 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. Patients may be photographed or videotaped by their parents/caregivers. The therapist who is treating the patient must be notified about the purpose of the video/photo. If there is any potential for other patients 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). 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:

- ☐ I ALLOW outdoor therapy.
- ☐ I DECLINE the use of outdoor therapy.
- ☐ Sunscreen permission: In the event where this patient 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 the patient's skin. 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 the patient 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.

INFORMATION RELEASE FORM:

I hereby give Unified Therapy Services permission to receive and release all information to/from the following individuals/groups/organizations during my care at Unified Therapy Services.

- ☐ Physician________________________________
- ☐ Department of Human Services____________
- ☐ Other __________________________________
- ☐ Medical Vendors__________________________
- ☐ School ________________________________
- ☐ Keystone AEA ___________________________

TELEHEALTH OPTIONS:

We offer traditional telehealth services with the patient at home. In the rare occasion that a therapist is working out of the office, we want to be able to provide our patients with the best treatment possible. Another option is to have the patient and one of our trained Rehabilitative Assistants work hand-in-hand in a treatment room at UTS while the therapist conducts telehealth from home. This option allows our patients to still have access to our facility and avoid the potential for technological obstacles.

- ☐ I authorize a Rehabilitative Assistant to coordinate treatment in a UTS treatment room while a licensed therapist facilitates via Telehealth.
- ☐ I do not authorize a Rehabilitative Assistant to coordinate treatment in a UTS treatment room while a licensed therapist facilitates via Telehealth.

UNIFIED THERAPY SERVICES PEDIATRIC 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. If this visit is a Telehealth session, I will be charged a $5 fee for a **No Call/ No Show** 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.

CONSENT FOR CARE/ASSIGNMENT OF BENEFITS/LIABILITY 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 willingly agree to comply with the stated and customary terms and conditions for participation in therapy services and other clinic operations including protection against and possible exposure to/illness from infectious diseases and I knowingly and freely assume all such risks.

I, for myself, 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, disability, 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 releases or otherwise, to the fullest extent permitted by law.

I APPROVE AND AGREE TO THE NOTED DIAGNOSTIC/REHABILITATIVE SERVICES AND RELEASES OF LIABILITY.

Patient Signature____ Date____________________

Parent/Guardian Signature *(If patient is a minor)* _____________________________ Date____________________

***By signing above, I certify that the previous pages of the new patient paperwork information are true and accurate to the best of my knowledge.**

BILLING/FINANCIAL:

Please provide the front desk staff with all insurance cards.

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:

☐ Mailed Notice of Privacy Practices & Notice of Privacy Practices Acknowledgement with Self-Addressed Stamped return envelope.
Date:____________________

☐ Follow up call made 4-5 days later. Date:____________________

☐ Copy sent home with patient. Date:________________________

☐ Final follow up call made. 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: