



Name: _____

Birth Date: _____

Language: English Other _____

Preferred Pronoun: _____

PARENT/GUARDIAN CONTACT INFORMATION:

Preferred Contact Name: _____

Relation: _____

Address: _____

Preferred Pronoun: _____

Cell Phone: _____

Other Phone: _____

E-mail address: _____

Employer: _____

Preferred method of contact: Call Text Email

May we leave a message? No Yes

Would you like to receive appointment reminders: Text

Email None

Secondary Contact Name: _____

Relation: _____

Address: _____

Preferred Pronoun: _____

Cell Phone: _____

Other Phone: _____

E-mail address: _____

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? No Yes

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

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.**

G. Do you need transportation to get to/from Unified for your appointments? No Yes

MEDICAL HISTORY:

- A. Patient Diagnosis (please include all): _____
- B. Allergies: Please include medication, food, and other: _____
- C. Is the patient latex sensitive? No Yes
- D. Does the patient have a history of seizures? No Yes
 - 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? No Yes
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: No Yes

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

SHARPS DISPOSAL: All sharps must be disposed of at home, we do not have a disposal container.

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.

- | | |
|---|--|
| <input type="checkbox"/> Physician _____ | <input type="checkbox"/> Medical Vendors _____ |
| <input type="checkbox"/> Department of Human Services _____ | <input type="checkbox"/> School _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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 *cancellations and reschedules must be done at least 2 hours in advance*. Messages may be left after hours and will be received the next business day.

I understand that if the above-named does not attend the scheduled appointment and if the staff of UTS must call, this will be considered a **No Call/No Show (NC/NS)** visit.

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

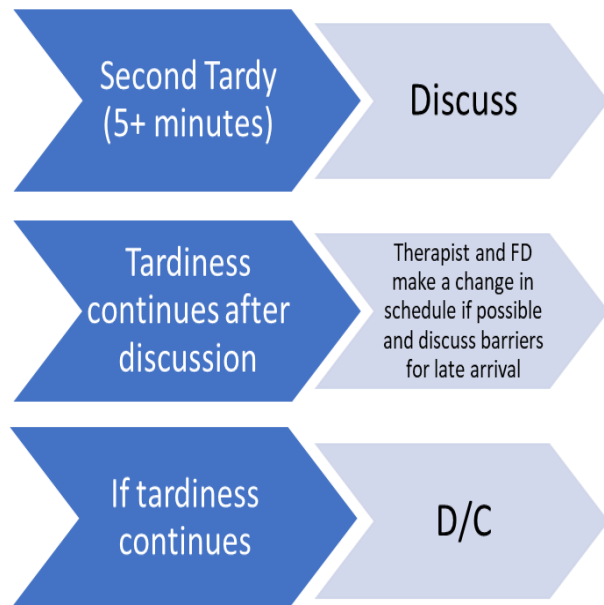
I understand that the above-named patient may see a different therapist from time to time.

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

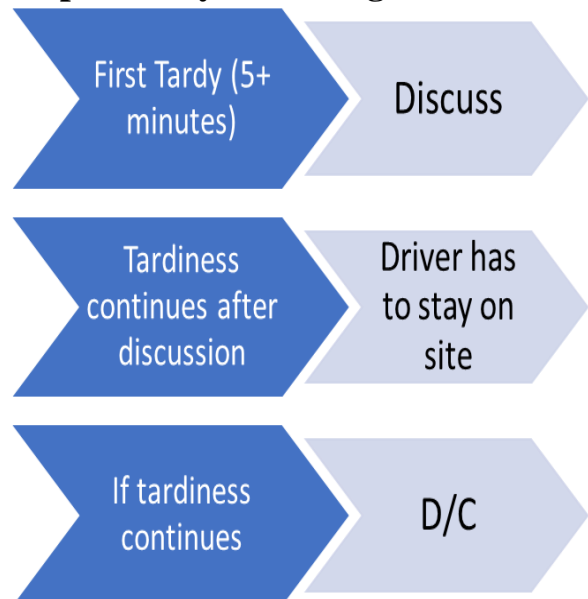
*Children under the age of 10 will need to wait with an adult until contact with their therapist has been made.

*If you are more than 25 minutes late to pick up your child without communication, the police will be called.

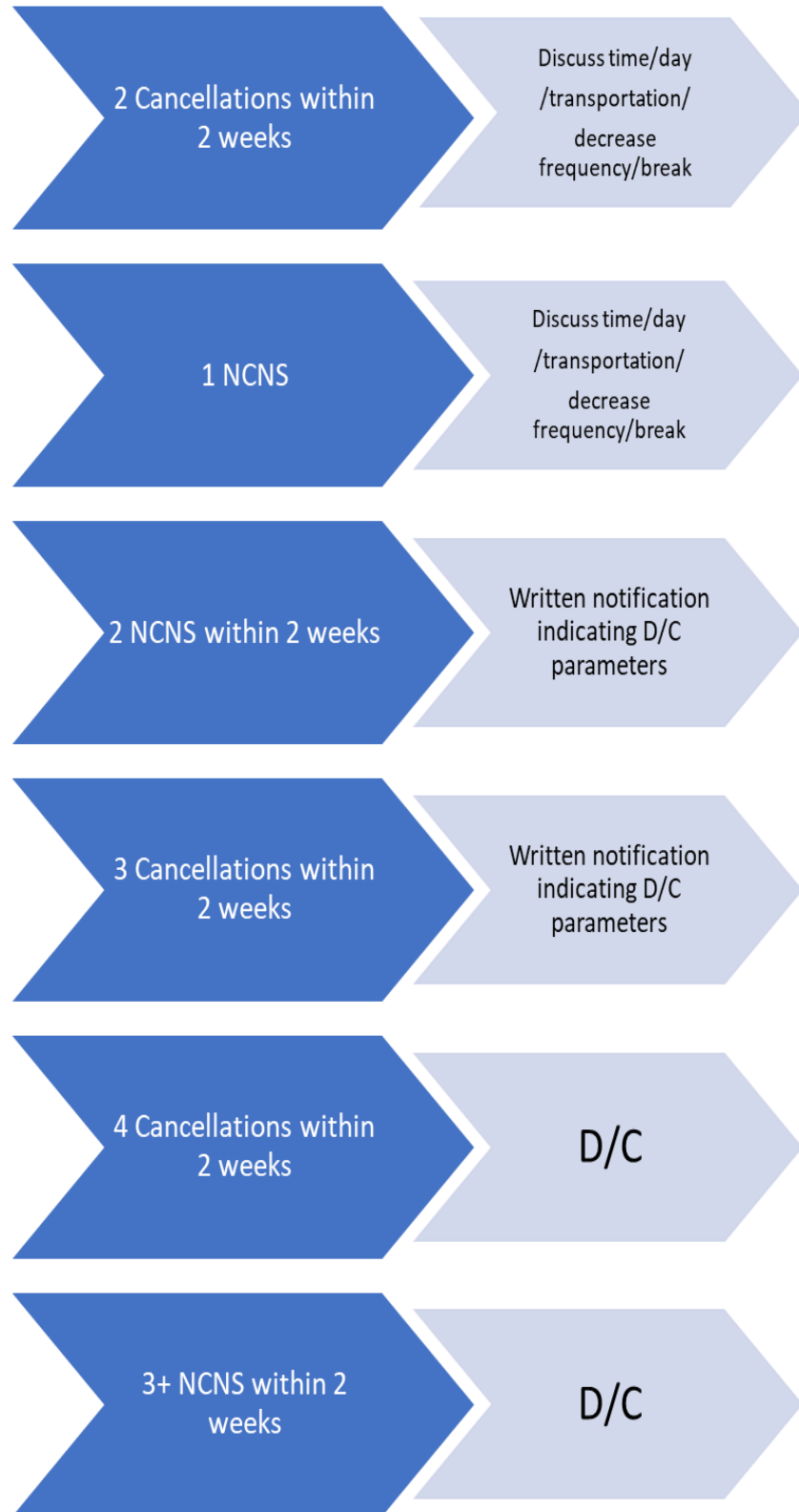
ARRIVAL TARDINESS-All Patients



DEPARTURE TARDINESS-For those unable to sit independently in waiting room



ATTENDANCE POLICY GUIDELINES



- I have read & understand the above mentioned Attendance Policy _____(initials)

CONSENT FOR CARE/ASSIGNMENT OF BENEFITS/LIABILITY WAIVER:

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.

I have read and understand the Attendance Policy as stated above.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____