PATIENT HEALTH HISTORY INFORMATION -PLEASE PRINT CLEARLY

Legal Name ________________________________ **Preferred Name/Nickname** ____________________

Birth Sex ☐ Male ☐ Female (required for Insurance) **Birth Date** _________________________________

Preferred Pronoun __________________________ **Language** ☐ English ☐ Other __________

Home Address ____ **Apt/Unit**________________

City ________________________________ **State** _____________ **Zip** ____________________

PARENT/GUARDIAN CONTACT INFORMATION:

Preferred Contact Name: ______________________________ Relation: ____________________________

Address (if different from above): ____

Cell Phone: ____ Preferred Pronoun: _____________________

E-mail address: ______________________________ Employer: ____________________________

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

Would you like to receive appointment reminders: ☐ Text ☐ E-mail ☐ None

Secondary Contact Name: _____________________________ Relation: ____________________________

Address (if different from above): ____

Cell Phone: ____ Preferred Pronoun: _____________________

E-mail address: ______________________________ Employer: ____________________________

EMERGENCY CONTACT:

Name: ____ Relation: ____________________________

Phone number: ______________________________

Resides at ☐ Home ☐ Residential Care Facility _________ ☐ Intermediate Care Facility _________

Do you have an ID WAIVER? ☐ Yes ☐ No If **YES**, please see Front Desk Staff

MARKETING:

Please tell us how you learned of our services or whom we may thank: __________________________

Upon discharge, may we send follow up postcards to your mailing address?: ☐ **Yes** ☐ **No**

EMS CONSENT:

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

□ 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.

School ________________________________ Teacher and Grade ______________________

IEP: □ Yes □ No If yes, please provide the front desk with this documentation to scan into their chart.

A. Does the patient attend daycare? □ Yes □ No If 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. Do you need transportation to get to/from Unified for your appointments? □ Yes □ No

E. Please list reason(s) for wanting therapy services: ____

____

____

MEDICAL HISTORY:

Patient Diagnosis (please include all) ____

Any major illness or injury resulting in the need for therapy ___________________________________

Allergies: Please include medication, food, and other: _______________________________________

Is the patient latex sensitive? □ Yes □ No

Does the patient have history of seizures? □ Yes □ No

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.

**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.*

MEDICATIONS:

Please list any medications including pills, injections, and/or skin patches, etc you are currently taking.
(You may choose to provide a medication list to our Front Desk Staff to scan into your medical history, if easier)

____

____

Please note that **ALL sharps must be disposed of at home- NO SHARPS CONTAINER AT UNIFIED THERAPY!

GENERAL INFORMATION:

Has the patient ever received therapy services in the past? ☐ Yes ☐ No If yes, describe ____________________

Does the patient utilize any adaptive equipment to assist with completion of daily activities? ☐ Yes ☐ No

If yes, please describe: ____

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

If difficulties were identified at birth, please indicate complications and outcomes: ____

Was the child carried to full-term pregnancy (at least 40 weeks)? ☐ Yes ☐ No If no, how many weeks? ______

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 **ALLOW** photos/videos to be taken.

☐ I **DECLINE** the use of photos/videos to be taken.

*I hereby **give my permission** to use ______________________'s first name and last initial to be used by **Unified Therapy Services** to identify accomplishments, birthdays, artwork, etc.

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 it in a safe place.*

INFORMATION RELEASE FORM:

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

☐ Non-referring Physician ________________________

☐ Dept of Health Services ________________________

☐ School/Employer________________________

☐ Medical Vendors ________________________

☐ Keystone AEA ________________________

☐ Other ________________________

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.

BILLING/FINANCIAL: Please provide the front desk staff with all insurance cards.

Unified Therapy Services Inc. **requires** a payment method (credit, debit, or HSA card) to be on file. Please see our Financial and Reimbursement Policy form for more information.

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 the *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.

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. 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 authorize Unified Therapy Services, Inc to run my card on file for the purpose(s) stated above and per the terms of this agreement. This authorization will remain in effect until I give written notice to Unified Therapy to change or terminate this authorization.

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 OF THE NOTED DIAGNOSTIC/REHABILITATIVE SERVICES.

Authorized Signature ____ **Date** ____________________________

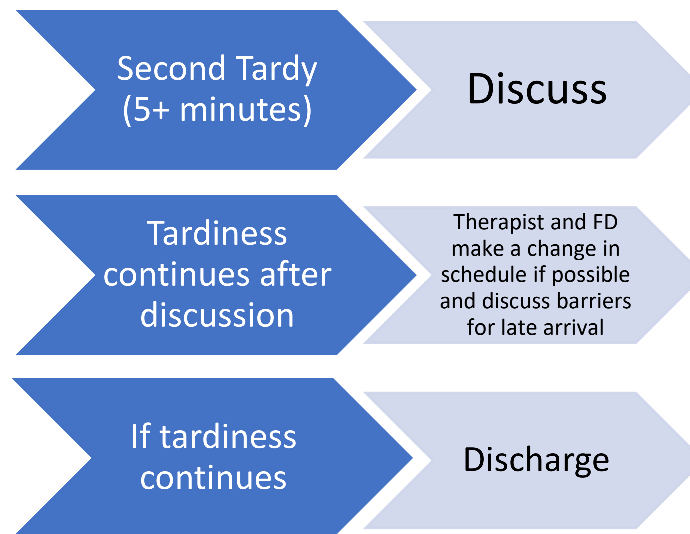
By signing above, I certify that the previous pages of the new patient paperwork information are true and accurate to the best of my knowledge.

UNIFIED THEARPY SERVICES PEDIATRIC PATIENT ATTENDANCE/TARDINESS POLICY

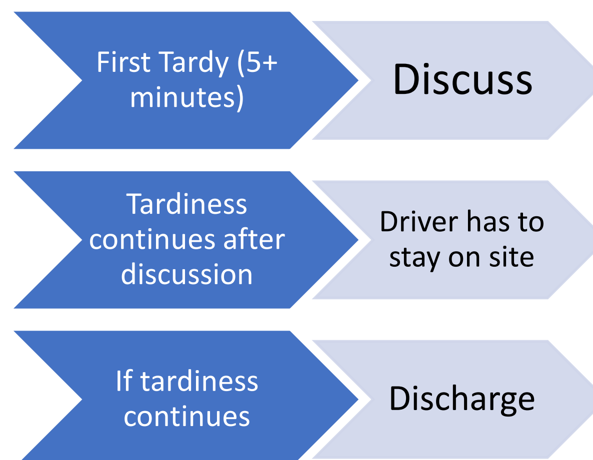
I understand that it is my responsibility to have _______________attend all scheduled therapy appointments or *cancellations and reschedules must be done at least 2 hours in advance.* Messages may be left after hours and will be received the next business day.

- 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. **This will result in a $10 charge. __________Initial**
- 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.**
- **If discharged more than 2x within the same calendar year due to attendance patient will not be able to return for 1 year from discharge date per Unified Therapy Staff discretion.**
- **If your attendance falls under any of these categories, you may be subject to weekly scheduling vs. block booking.**

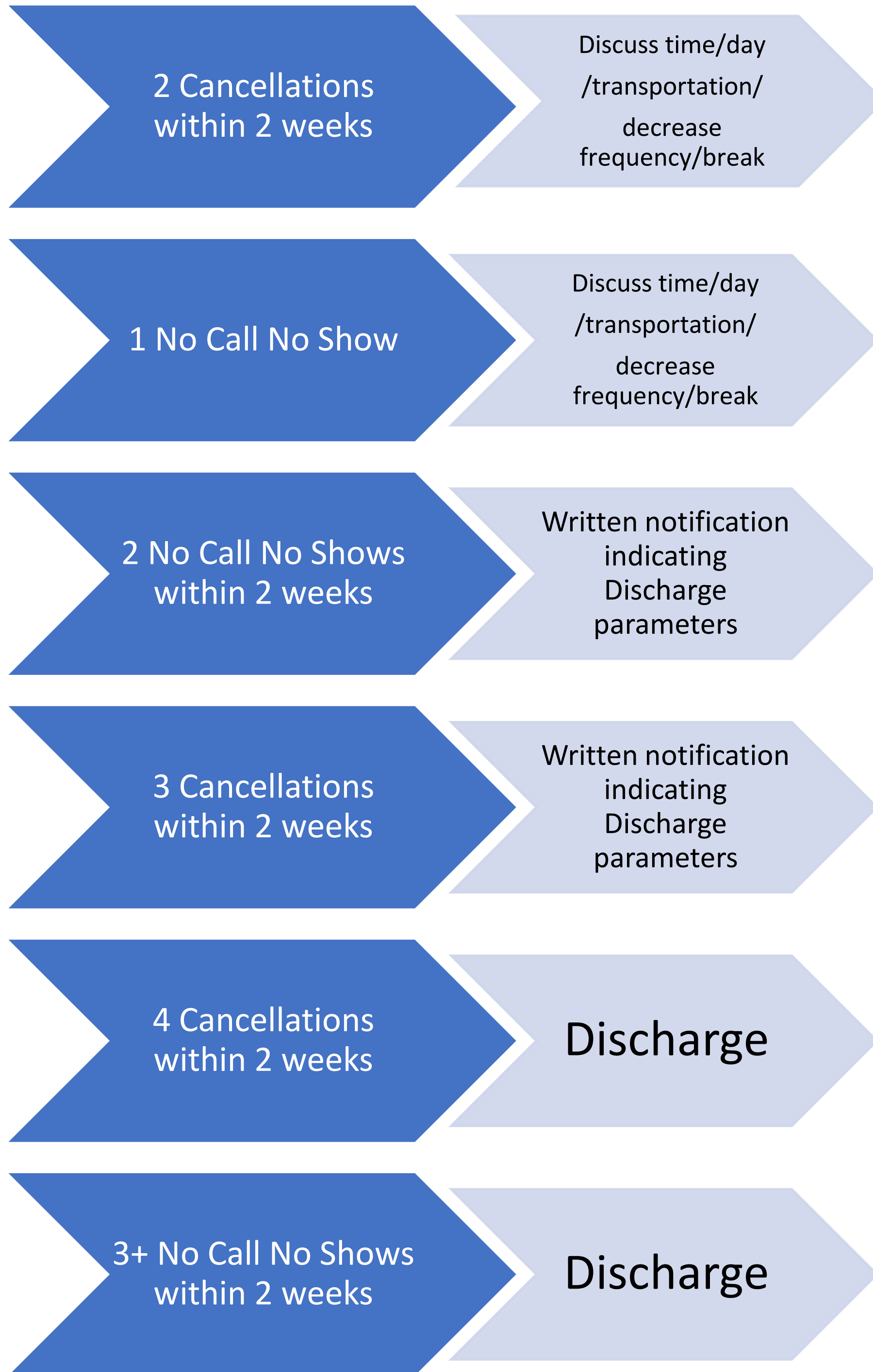
ARRIVAL TARDINESS-All Patients



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



ATTENDANCE POLICY GUIDELINES



I have read & understand the above-mentioned Attendance Policy ___________________________(Signature)