Achieve
Pediatric Therapy & Rehab

Patient Intake/History Form

General Information		
Patient Name:		
Sex: M F	Date of Birth: Mo: Day:	Yr:
Primary Care Physician:		
Parent's Name:		
Address:	Phone: Home	Work:
City:	State:	Zip:
Emergency Contact:	Relationship:	Phone:
Reason for therapy referral:		
Known Allergies:		
Current Medications:		
Medical/Surgical History(Prior hospitalizations, surgeries):		
Childhood Diseases:		

Patient Intake/History Form cont.

Please specify any religious/cultural considerations:

Is there anything we need to know that is not covered on this form? If so please explain:

Patient's goals for treatment:

_____ _____

Patient or Parent/Guardian Signature Date

IN CASE OF AN EMERGENCY, PLEASE PERFORM ANY LIFE SAVING TECHNIQUE (I.E. CPR, HEIMLICH MANUEVER) THAT YOU DEEM NECESSARY IN ORDER TO PRESERVE THE LIFE OF MY CHILD.

_____ _____

Parent/Guardian Signature Date

How did you hear about us?

_____Doctor referral _____Internet _____Current patient/friend

Other: _____

This Admissions Packet Includes:
Attendance Policy
Notice Regarding Insurance Changes
Patient Authorization/Consent to Treatment

Please sign and date in the appropriate boxed area at the end of each section. Please do not hesitate to ask any questions regarding the information in this packet.

ATTENDANCE POLICY

ACHIEVE Pediatric Therapy and Rehab strives to provide each patient with the highest quality of care while accommodating your schedule. We reserve time allotments for each patient; therefore, keeping your appointments on a consistent basis is a key factor in making progress with your/your child's therapy goals and care plan.
We respectfully request a **24 hour notice** of appointment cancellations. We do understand on occasions unavoidable situations which will prevent you from getting to therapy. If we do not receive advanced notice of a cancellation, it will be considered a "no show-no call" episode.
You will be charged a fee of $50 in the event that you do not provide advance notice regarding a cancellation. It is our policy that if a patient has 2 "no show-no call" episode or 3 consecutive cancellations, that their treatment program may be terminated.

I have read and understand the above attendance policy.

_____ _____

Patient/Parent signature Date

INSURANCE CHANGES

Please notify our office immediately of any insurance changes made to your policy. For example: Change to a different primary insurance due to Employer group **OR** change in your PCP or Physician group **OR** change in insurance type (such as PPO, HMO, POS, EPO). The changes are usually effective the first of each month. Failure to notify ACHIEVE of changes may result in patient financial obligation for all unpaid charges.

I have read and understand the above Insurance Changes policy.

_____ _____

Patient/Parent signature Date

PATIENT AUTHORIZATION/CONSENT TO TREATMENT

Authorization to Release Information:

The patient, or his/her legal guardian, agrees to the release of general information as concerns his/her therapy treatment upon receipt of an inquiry directed to ACHIEVE. In addition, patient, or legal guardian, agrees to the release of all medical records and pertinent medical information for this outpatient admission to any insurer, governmental agency providing benefits, or to anyone liable for therapy charges.

Authorization of Assignment of Insurance Benefits:

The patient, or legal guardian, assigns to and authorizes payment directly to ACHIEVE Pediatric Therapy & Rehab all benefits payable under the terms of any insurance policy providing benefits for outpatient charges. The patient, or legal guardian, assumes responsibility for any health insurance deductions and co-payments responsibility of remaining reasonable charges. The undersigned, whether one or more, agrees to pay any charges of ACHIEVE Pediatric Therapy & Rehab in excess of benefits paid. If the patient is covered by Medicaid, he hereby assigns to the Texas State Board of Health all claims against third parties, including tort feasors and insurance companies, who may be liable for any of the medical expense to the extent that such expenses are paid by Medicaid.

Guarantee of Account:

In consideration of the therapy services furnished and to be furnished by ACHIEVE Pediatric Therapy & Rehab, I/We hereby guarantee to you the payment of the account for services rendered or to be rendered to said patient (together with previously incurred and yet unpaid charges). I/We agree to pay these accounts when due. For the payment of such accounts I hereby waive all claims of exemption and agree to pay a reasonable attorney's fee for the collection of these accounts if placed in the hands of an attorney for collection. I/We agree to abide by all rules and regulations of ACHIEVE Pediatric Therapy & Rehab.

Consent to Treatment:

This constitutes consent to admit to outpatient therapy at ACHIEVE Pediatric Therapy & Rehab and to perform such routine treatment as ordered by your physician, physician's assistant, or nurse practitioner. It is acknowledged that the practice of medicine is not an exact science and that no guarantees have been made as to the result of treatment as an outpatient.

I have read and understand the above paragraphs about the Authorization to Release Information, Authorization of Assignment of Insurance Benefits, Guaranty of Account, and Consent to Treatment.

_____ _____

Patient/Parent signature Date

Consent for the Use and Disclosure of Protected Health Information

By signing below, you consent to the use and disclosure of your protected health information by ACHIEVE PEDIATRIC THERAPY & REHAB, our staff and our business associates for treatment, payment and health care operations purposes. For a more detailed description of our uses and disclosure of protected health information, please review our Notice of Privacy Practices ("Notice"),which you acknowledge receiving on this date. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting us at 512-260-6990 and requesting a revised Notice. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

AGREED AND ACKNOWLEDGED: _____ _____

Patient/Parent Signature Date

My email address is: _____.

Our office may occasionally email you regarding your child's therapy and/or performance during therapy. Also, our office will email any office closures, schedule changes, account/insurance notices, and special events. I understand that email is NOT a secure form of communication.

- Information regarding my child's therapy session and/or performance can be released to the following individuals:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Patient/Parent Signature Date