Rigby Pediatric Clinic
Rehab Specialists OF IDAHO
Occupational, Physical & Speech Therapy

PATIENT INFORMATION

Child's Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Gender: (Circle) Male Female

Home Address: _____ City: _____State: _____ Zip: _____

Billing Address: (If different) _____ City: _____State: _____ Zip: _____

Allergies/Sensitivities: _____

Primary Contact Parent/Guardian: _____ Date of Birth: _____

Phone: _____ Texting: (Circle) YES NO Email: _____

Secondary Contact Parent/Guardian: _____ Date of Birth: _____

Phone: _____ Texting: (Circle) YES NO Email: _____

Child resides with: _____

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN):

Name: _____

Relationship: _____ Phone: _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ Policy Holder's Name: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

My child does not have any other medical insurance coverage other than these listed. **Initial: _____**

I will immediately notify RSI of any insurance changes. **Initial: _____**

Primary Care Provider Name/Office: _____

Phone: _____

Referring Physician Name/Office: _____

Phone: _____

How did you hear about us? (Circle) Doctor Friend Social Media Web Search Teacher Insurance Other: _____

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PATIENT ACKNOWLEDGEMENTS AND AGREEMENTS

NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have reviewed and been offered a copy of the Notice of Privacy Practices for Rehab Specialists of Idaho Rigby Pediatric Clinic. I have also reviewed and been offered a copy of the RSI-Rigby Attendance Policy and Financial Responsibility Policy. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and healthcare operations.

Signature: _____ **Date:** _____

LIABILITY RELEASE:

I acknowledge the risks and potential for risks of participants participating in therapeutic activities, such as aquatic therapy, outdoor therapeutic activities, gym activities etc. However, I also acknowledge that the benefits to my child and/or the clients I work with are greater than the risk assumed. I, hereby, am legally bound, for myself, my heirs and assigns, executors and administrators, waive and release forever all claims for damages against Rehab Specialists of Idaho, and board of directors, instructors, therapists, volunteers, and/or employees of any and all injuries and/or losses I may sustain while participating in Rehab Specialists of Idaho therapeutic activities.

Signature: _____ **Date:** _____

EMERGENCY MEDICAL RELEASE:

In the event medical attention is required for my child while on or near the premises of RSI-Rigby, I give my consent to implement treatment and/or contact emergency personnel.

Signature: _____ **Date:** _____

PHOTO RELEASE:

I give consent to and authorize the use and reproduction thru email and/or text and/or any other electronic communication of any kind with all photographs and any audio-visual materials taken of said patient of any and all photographs and any other audio-visual materials taken of said patient for therapeutic and educational activities as related to said patient's Plan of Care for the benefit of the patient with all risks assumed of any kind.

Signature: _____ **Date:** _____

ELECTRONIC COMMUNICATION:

I consent to communicate with Rehab Specialists of Idaho Pediatric Clinic through electronic means, including email, text messages and other digital communications. Electronic communications may include, but are not limited to, appointment reminders, health information, treatment updates, billing information, and responses to inquiries. Electronic communications may be intercepted, forwarded, stored, or changed without detection. The security of electronic communications cannot be guaranteed, which may lead to unauthorized access to your personal information. I understand and accept the risks and agree to receive electronic communications from RSI.

Signature: _____ **Date:** _____

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PEDIATRIC PATIENT HISTORY

Space is provided on the final page of this form for any long answers or explanations.

Date: _____ Child's Name: _____ Date of Birth: ___ _____

Age: _____ Homeschooled? (Circle) YES NO Grade: _____School: _____

Primary language spoken in the home: _____ Other languages spoken: _____

Diagnosis: _____ Primary Doctor: _____

List persons living in the home with the child. Parents: _____

Siblings (Name and Age):_____

Other: _____

Has your child ever had an evaluation or received occupational, physical, or speech therapy before?

When: _____ Where: _____ Therapist: _____

Did your child receive any services from the Idaho Infant-Toddler Program? (Circle) YES NO

Does your child receive occupational, physical, or speech therapy at school? (Circle) YES NO

Circle all areas of concern:

Speech Language Following Directions Attention Memory Reading

Writing Social Skills Throwing/Catching Eating Constipation Bladder Control

Balance Walking Falls Frequently Coordination Endurance

List your child's strengths:

List your child's weaknesses:

What things would you like to see your child do, or do better? What are your goals for therapy? Reason for referral?

Do you have any concerns about your child's performance in school? (Circle) YES NO (If yes, please explain)

<u>DEVELOPMENTAL HISTORY:</u>

This child is my: (Circle) Biological Adopted Foster Child

List any complications that occurred during pregnancy and which month they occurred:

Birth Weight: _____ Birth Length: _____ Birth Place: _____

Was the baby born after a full-term pregnancy? (Circle) YES NO If no, how many weeks early? _____

How long was labor? _____ Was labor induced: (Circle) YES NO

Type of delivery: (Circle) Vaginal Breech Cesarean

Was the baby transferred to the NICU or required extra time in the hospital? (Circle) YES NO

If yes, how long did they stay? _____

What type of medical support did they need? _____

Circle any conditions that existed for the baby at birth:

Paralysis	Birth defects	Feeding tube (Length of time) _____
Fractures	Multiple births	Needed Oxygen (Length of time) _____
Seizures	HIV Positive	Surgeries (Reason) _____
Bruised Head	Did not cry quickly	Blue Color for a long time
Cord around neck	Low Apgar scores	Other _____

Indicate the approximate age at which your child:

Held their head up unsupported _____ Sat unsupported _____Crawled _____

Walked _____Rode a bicycle/tricycle _____ Walked up/downstairs _____

Eat finger foods _____Eat with a spoon _____Erupted first tooth _____

Potty Trained_____ Make babbling/cooing sounds_____ Say his/her first words_____

Has your child ever been in the hospital, had a serious accident, or had a serious illness? (If yes, please explain)

Has your child had frequent illnesses or infections, such as ear infections? (If yes, please explain how often and what kind of infection)

Does your child have seizures? (Circle) YES NO

How often? _____ Certain time of day? _____

How do you recognize a seizure and what do you do for your child when they are having a seizure?

Please list all medications your child is presently taking and their purposes:

Has your child seen a specialist for any medical condition? (Please list which doctors, medical concerns, and approximate dates)

VISION AND HEARING INFORMATION:

My child has:

Had a hearing exam: (Circle) YES NO Date: _____ Results: _____

Had a vision exam: (Circle) YES NO Date: _____ Results: _____

Does your child exhibit any of the following? (Circle all that apply)

Complaints of headache or eye pain	Excessive blinking or squinting	Turning or tilting head
Eyes turn in or out, up or down	Rubs eyes frequently	Gets close or near to work or see
Closes or covers one eye	Chronic red eyes	

ADAPTIVE SKILL INFORMATION:

On a scale of 1 to 4, how well does the child function in the following areas? (Circle only one)

1=Completely dependent on others. Needs lots of help or cues.
4=Completely independent. No difficulties in this area.

Dressing Upper Body	1	2	3	4	Not Applicable
Dressing Lower Body	1	2	3	4	Not Applicable
Toileting	1	2	3	4	Not Applicable
Eating (breast or bottle)	1	2	3	4	Not Applicable
Eating (soft foods off spoon)	1	2	3	4	Not Applicable
Eating (with fingers)	1	2	3	4	Not Applicable
Eating (with utensils)	1	2	3	4	Not Applicable
Playing with familiar peers	1	2	3	4	Not Applicable
Playing with unfamiliar peers	1	2	3	4	Not Applicable
Handwriting	1	2	3	4	Not Applicable
Frustration tolerance	1	2	3	4	Not Applicable
Sleeping routine	1	2	3	4	Not Applicable

Grooming (hair)	1	2	3	4	Not Applicable
Grooming (bathing)	1	2	3	4	Not Applicable
Grooming (teeth)	1	2	3	4	Not Applicable
Maintaining attention to tasks	1	2	3	4	Not Applicable
Entertaining self	1	2	3	4	Not Applicable
Hand/Eye coordination	1	2	3	4	Not Applicable
Balance	1	2	3	4	Not Applicable
Following verbal directions	1	2	3	4	Not Applicable
Safety awareness	1	2	3	4	Not Applicable
Cutting with scissors	1	2	3	4	Not Applicable

Does your child have feeding concerns? (Circle) YES NO

Check all areas of concern:

_____Excessive length of time to drink a bottle

_____Regurgitation of liquids/solids through nose

_____Difficulty chewing/swallowing meats

_____Picky eater

_____Sucking or nursing

_____Difficulty gaining weight

_____Choking and/or gagging

_____Excessive drool

Please explain:

SOCIAL INFORMATION:

My child: (Check all that apply)

_____Gets along with other children.

_____Prefers to play NEXT TO other children (minimal to not talking among children).

_____Prefers to play WITH other children (playing and talking jointly).

_____Prefers to play alone.

Describe your child's play. What do they like to play? What are their favorite games and toys?

List and describe any concerns you may have about your child's behavior:

SPEECH, LANGUAGE, AND HEARING INFORMATION:

Circle all areas of concern:

_____Production of speech sounds _____Hearing

_____Understanding/following directions _____Understanding/speaking English

_____Understand what is said to him/her _____Stuttering/fluency

_____Voice _____Expressing ideas, wants, needs (language)

Describe/give examples of your concerns with the areas you checked above:

Are your concerns related to a specific incident/event? (If yes, please describe)

Does your child seem to recognize his/her communication difficulty? _____ (If yes, what does the child do?)

If your child's communication varies, under what conditions does it become:

1. Better: _____
2. Worse: _____

Check the items that your child seems to do more than other children the same age:

_____Avoids speaking at school/preschool/daycare. _____Avoids speaking to adults.

_____Avoids speaking when playing with others. _____Avoids saying certain words.

_____Avoids speaking at home. _____Cries when unable to communicate.

_____Avoids speaking to children. _____Becomes aggressive when unable to communicate.

Give examples of your child's first words: _____

Does your child put words together (ex: more milk)? (Circle) YES NO
How many words are in your child's longest utterances? Please give examples:

Does your child make sounds incorrectly? _____ If yes, please give examples:

How well is your child understood by: (Percentage of time)

Parents: _____ Family Friends: _____ Siblings: _____ Strangers: _____

My child can: (Check all that apply)

_____Say a nursery rhyme

_____Answer simple Questions

_____Get a common object when asked to do so

_____Follow one-step commands (“wash your hands”)

_____Follow more difficult directions (“get your book and give it to dad”)

____ Tell about past events

____ Tell a simple story

____ Tell about immediate events

____ Remember what is told to him/her

Does your child use the same, more, or less number of words as other children the same age? (Circle) SAME MORE LESS

Please use the space below to continue any long answers or explanations):

ALL REMAINING PAGES MUST BE REVIEWED, BUT DO NOT NEED TO BE RETURNED

RSI-RIGBY ATTENDANCE POLICY

Consistent Attendance – Rehab Specialists of Idaho therapists and staff strive to ensure that each patient can reach their full potential, and to do that, we need consistency in their therapy services and interventions. When a patient misses their appointment it hinders their progress, as well as taking an appointment time from another patient.

Signed Plan of Care – Each patient receiving therapy services has a Plan of Care created by the therapist with your input. The Plan of Care states the amount of therapy the patient will receive, and it is signed and agreed on by their physician. This is the same as taking medication, it is prescribed by your doctor, and you are expected to receive this amount of therapy.

No Show Policy – If you have three "No Shows" our policy states that the patient may be removed from the schedule and will need to call to reschedule or wait until another appointment is available.

Notifying Your Doctor – If you fall below 75% attendance, we may be obligated to contact your doctor and inform them of your decreased attendance and the risk to the patient of not reaching their therapy goals. Failure to maintain an attendance rate above 75% may result in the patient being removed from the schedule and will need to call to reschedule or wait until another appointment is available.

Illness Cancellation Policy – Colds are very common and often shouldn't limit attendance unless the child is running a fever or coughing uncontrollably, or if the child doesn't feel well enough to tolerate therapy. We will not provide therapy to clients if the child has a fever, lice, pink eye, unidentified rash, or any other possibly contagious symptoms including diarrhea and vomiting. Please let us know as soon as possible (at least 24-hours in advance would be preferred) if your child is unable to attend therapy. Should surgery or illness require extended or repeated absences, a doctor's note may be requested.

FINANCIAL RESPONSIBILITY POLICY

Payment at Time of Service – Rehab Specialists of Idaho is a preferred provider with many insurance companies. We bill all contracted insurance carriers, and require your insurance information at, or prior to, the first visit to do so. Copays are due at the time of service; this is an agreement made between the subscriber and the insurance company. Clients with unmet deductibles may contribute a deposit towards the costs of each visit at the time of service. The client is ultimately responsible for the timely payment of any account balance.

Statements will be mailed monthly and are due within the time frame noted at the bottom of the statement. We accept payment by cash, check, and most major credit cards. We recognize that clients may occasionally experience financial challenges; if there is a need to discuss a payment plan, please contact our Billing Department 208-933-4479.

Collections – Rehab Specialists of Idaho will make every effort to work with clients to arrange satisfactory payment of any account balance, however if payment is not received within 90 days of the initial invoice and the office has not been contacted to arrange a payment plan, collection activities will commence. Rehab Specialists of Idaho utilizes the services of an outside collection agency.

Billing Your Insurance – Rehab Specialists of Idaho will bill insurance based upon the information provided on the client intake forms. Clients are responsible for notifying our office of any changes with insurance (i.e., payer, group number, member ID, etc.) in a timely manner. Charges for appointments during any coverage change or lapse will be the client's responsibility.

Clients are responsible for understanding any insurance benefit coverage, limits, requirements, maximums, and for tracking the utilization of such benefits. Please note that the benefits quoted by your insurance are not a guarantee of payment. Rehab Specialists of Idaho will do its best to help determine benefits and eligibility though we make no guarantee that the information is 100% correct. Please be aware that some services provided may not be covered based upon your policy.

Notice of Privacy Practices (HIPPA Acknowledgement/Consent) – This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

We are required by federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. This notice takes effect September 1, 2007, and we will follow the privacy practices that are described in this notice while it is in effect.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about your treatment, payment, and health care operations.

For Treatment – We may use or disclose medical information about you to facilitate medical treatment or services by providers, doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you to ensure necessary information to diagnose or treat you.

For Payment – We may use and disclose your medical information to determine eligibility for benefits, facilitate payment for the services you receive from health care providers, and to determine benefit responsibility or coordinate coverage. For example, this would be submitting your bill to your insurance company for reimbursement.

Healthcare Operations – We may use or disclose, as needed, your medical information to conduct certain business and operational activities, normal office procedures, such as quality control, case management and coordination of care. For example, we may use a sign-in sheet at the registration desk or call out your name in the waiting room to take you to an assigned room for treatment. We may also share your health information with third party "business associates" such as billing or transcription services.

Uses and Disclosures Based on Your Written Authorization – Other uses and disclosures of your health information will be made only with your authorization, unless otherwise permitted or required by law. An example of this would be when the law requires that we report information to government agencies and law enforcement personnel. If you give us written authorization, you may revoke it in writing at any time.

Your revocation will not affect any use or disclosures permitted by your authorization; we will not disclose your health information except as described in this notice.

Others Involved in Your Health Care – Unless you object, we may disclose to a member of your family, close friend, or any other person you identify that directly relates to involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Marketing – We may use your health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your health information to a business associate to assist us in these activities.

Research – We may use or disclose your health information for research purposes in limited circumstances.

Public Health and Safety - We may disclose your health information to the extent necessary to avert a serious and imminent threat to your health and safety or health and safety to others. We may disclose your health information to government agencies authorized to oversee health care systems, programs, and to public health authorities for public health purposes.

Health Oversight – We may disclose your information to a health oversight agency for activities authorized by law, such as audits, investigation, and inspection. Oversight agencies include benefit programs, regulatory programs, and civil rights laws.

Lawsuits and Disputes – If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

PATIENT RIGHTS

Right to Inspect and Copy – You have the right to look at or get copies of your protected health information, with limited exceptions. You have the right to inspect and copy medical information that may be used to make decisions about you, submitting your request in writing. We may deny your request to inspect or copy in certain very limited circumstances. If you are denied access to medical information, you have the right to request an amendment for as long as the information is kept.

Accounting of Disclosures – You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after September 1, 2007. We will provide you with the date on which we made the disclosure and the name of the person or entity to which we disclosed your protected health information.

Restriction Requests - You have the right to request (in writing, signed by an authorized person to make such an agreement on our behalf) that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement.

Confidential Communication – You have the right to request that we communicate with you in confidence about your protected health information by alternative means or at an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, and if it continues to permit us to bill and collect payment from you.

Right to Correct, Update, and Amend – You have the right to request that we amend your protected health information. Your request must be in writing and must explain why the information should be amended.

We may deny your request if we did not create the information, you amended or for certain other reasons. If we deny your request, we will do so with a written explanation.

If we accept your request to amend the information, we will make reasonable efforts or inform others, including people or entities you name, and include the changes in any further disclosure of the information.

If you want more information regarding our privacy practices or have questions or concerns, please contact us using the information below:

Rehab Specialists of Idaho
Rigby Pediatric Clinic
Office Manager
Rigby, ID 83442
208-228-0625
208-745-2529 Fax

If you believe we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may comment using the information below:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257 or Toll Free 1-877-696-6775

We support your right to protect the privacy of your protected health information.
You will not be penalized for filing a complaint.