Name_____

Please mark any food allergies that your child has:

- ◯ Eggs
- ◯ Milk
- ◯ Gluten
- ◯ Peanuts
- ◯ Other _____
- ◯ Other_____
- ◯ Other_____

Anything else we should be aware of?

_____

_____

_____

_____

Rehab Specialists OF IDAHO
Occupational, Physical & Speech Therapy

36 Professional Plaza Suite 110 Rexburg, ID 83440 Phone 359-9570/Fax 359-9580

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Federal Government has developed regulations in an attempt to ensure the health care privacy of patients.

I acknowledge that I was provided a copy of the *Notice of Privacy Practices* and that I have read, or had the opportunity to read if I chose so, and understood.

_____ Patient

Name (please print) Date

_____

Signature Relationship to Patient

Rehab Specialists OF IDAHO
Occupational, Physical & Speech Therapy
Professional Plaza Suite 110
Rexburg, Idaho 83440
208-359-9570
208-359-9580 Fax

Notice of Privacy Practices – 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 in order 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, 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 in 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 to 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
Occupational, Physical & Speech Therapy

Office Manager
36 Professional Plaza Suite 110
Rexburg, Idaho 83440
208-359-9570
208-359-9580 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.

Rehab Specialists OF IDAHO
Occupational, Physical & Speech Therapy

36 Professional Plaza Suite 110 Rexburg, ID 83440 Phone 359-9570/Fax 359-9580

IN CASE OF EMERGENCY:

Please Contact:

Name: _____ Phone: _____

Physician Preference: _____ Phone: _____

Hospital and Town: _____

In case of emergency, I give permission to Rehab Specialists of Idaho to secure medical treatment including x-ray, surgery, hospitalization, medication, & to call an ambulance if they deem it necessary.

Date: _____Signature: _____ (self, parent or legal guardian if <18 yrs)

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.

Date: _____Signature: _____ (self, parent or legal guardian if <18 yrs)

LIABILITY RELEASE: I acknowledge the risks and potential for risks of participants participating in therapeutic activities, such as aquatic therapy, outdoor therapeutic activities, ect. 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.

Date: _____Signature: _____ (self, parent or legal guardian if <18 yrs)



36 Professional Plaza Suite 110 Rexburg, ID 83440 Phone 359-9570/Fax 359-9580

Patient Information

Patient Name: _____ Sex: M F Age: ____ Birth Date: ___/___/____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Responsible Party

Parent/Guardian: _____ Relationship: _____

***Parent/Guardian Phone:** _____ ***Alternate Phone:** _____

***Parent Email:** _____

Emergency Contact

Name & Relationship: _____ Phone: _____

Primary Insurance

Insurance Name: _____

Guarantor Name: _____

ID #: _____

Secondary Insurance

Insurance Name: _____

Guarantor Name: _____

ID #: _____

***Primary Care Physician:** _____ Referring Physician: _____

I guarantee payment of all physical, occupational or speech therapy charges for treatment provided to the above named patient to Rehab Specialists of Idaho. I understand that I am financially responsible for all charges including but not limited to all copayments, deductibles and expenses not covered or paid by insurance. I understand that the unpaid balance is due in full upon discharge and that there is a monthly charge of 1.5% (18% per annum) applied to the unpaid balance after 30 days from discharge. If legal action is taken against this account I agree to pay for all legal fees associated with the action. I agree to comply with the policies of said clinic as explained on the accompanying page. I understand that I must give 24 hour notice of cancellation if I am unable to keep a scheduled appointment. In the event that industrial or liability insurance exhausts or refuses to pay, I authorize Rehab Specialists of Idaho to bill my health insurance. I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment to be paid directly to the above named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

_____ _____

Signature of Patient or Parent/Guardian Date

How did you hear about us? _____

Thank you for choosing Rehab Specialists of Idaho as your preferred provider. We recognize that the financial aspects of health care can be confusing. The Rehab Specialists of Idaho team will do its best to help make the process as easy as possible. In order to serve you the best we can, we ask that you review the following policies and practices.

Financial Responsibility

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 on 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.

Insurance Billing Policy

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 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.

Failure to adhere to the policies listed may result in the client's services being put on hold.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

Please sign the policy receipt and acknowledgement and agreement form to verify that you have been notified of our financial policy.

_____ _____

Signature of Patient, Parent, or Guardian Date

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. Due to our concern for all our clients, we are implementing this policy.

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.

- **If you have 3 No Shows,** our policy states that the patient will be removed from the schedule and will need to call in to reschedule.
- **If you fall below 75% attendance,** your doctor will be contacted to inform them of your decreased attendance and the risk for the patient to reach their goals.

Examples of Plan of Care frequency prescribed and expected number of appointments:

1x a week for 26 weeks	75% is 20/26 appointments	can miss 6 appointments
2x a week for 26 weeks	75% is 39/52 appointments	can miss 13 appointments
Every other week for 26 weeks	75% is 10/13 appointments	can miss 3 appointments
1x a week for 52 weeks	75% is 39/52 appointments	can miss 13 appointments
2x a week for 52 weeks	75% is 78/104 appointments	can miss 26 appointments
Every other week for 52 weeks	75% is 20/26 appointments	can miss 6 appointments

If you are not able to come to your regularly scheduled appointment, you must call to cancel, or it will be marked as a "no show".

I have read and agree with this policy and understand the 75% attendance and no-show policy.

Guardian printed name:_____

Guardian signature:_____

Rehab Specialists OF IDAHO
Occupational, Physical & Speech Therapy

36 Professional Plaza Ste 110, Rexburg, ID 83440 Phone 208 359-9570/Fax 208 359-9580

PEDIATRIC PATIENT HISTORY

Date:_____ Child's Name:_____ Date of Birth:_____
Age:_____ Does your child attend school? _____What grade? _____Where?_____

Primary language spoken in the home:_____Other languages spoken?_____
Diagnosis: _____ Doctor:_____

Please 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 and by Whom?

Did your child receive any services from the Idaho Infant-Toddler Program?

Does your child receive SPEECH, PHYSICAL, or OCCUPATIONAL therapy at school? (Please Circle)

Please 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	

Please list your child's strengths:

Please 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?

DEVELOPMENTAL HISTORY:

Check which is applicable: This child is my _____biological, _____adopted, _____ foster child?

Please list any complications which occurred during pregnancy and which month they occurred.

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

Was the child born after a full term pregnancy:_____ If no, how many weeks: _____

How long was labor:_____ Was labor induced:_____

Were instruments used:_____ Type of delivery: Vaginal Breech Cesarean

Was the baby transferred to the NICU or required extra time in the hospital? Yes or no ? If yes, how long did they stay?_____ What type of medical support did they need?_____

Please 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 (Why?)_____
Bruised Head	Did not cry quickly	Blue Color for a long time
Cord around neck	Low Apgar scores	Other? _____

Please indicate the approximate age at which your child……?

Held their head up unsupported _____ Sat unsupported _____Crawled _____
Walked _____Rode a bicycle/tricycle _____ Walked up/down stairs _____
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? 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 purpose?

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

VISION AND HEARING INFORMATION: **My child has…**

_____ had a hearing exam: Date:_____ Results: _____

_____ had a vision exam: Date: _____ Results: _____

Warning signs of vision problems…. Does your child exhibit any of the following: ***Please Circle***

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

Did your child have feeding problems? _____ Comments:_____

_____ Excessive length of time to drink a bottle **_____sucking or nursing**

_____Regurgitation of liquids/solids through nose **_____ Difficulty gaining weight**

_____ Difficulty chewing/swallowing meats **_____Choking and/or gagging**

_____Picky eater **_____ Excessive drool**

SOCIAL INFORMATION:

My .... (check all those 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

Please describe your child's play. What does he/she like to play? What are his/her favorite games and toys?

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

SPEECH, LANGUAGE, AND HEARING INFORMATION:

Please check all areas below that are of concern to you with regard to your child:

_____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 so, 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 when playing with others

_____Avoids speaking at home

_____Avoids speaking to children

_____Avoids speaking to adults

_____Avoids saying certain words

_____Cries when unable to communicate

_____Becomes aggressive when unable to communicate

Please give examples of your child's first words_____

Does your child put words together (ex."more milk")?_____ How many words are in your child's longest utterances? Please give examples:

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

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

Parents?_____ Family Friends? _____ Siblings?_____ Strangers? _____

My child can…(check those 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 one)

**Thank you for completing this lengthy form. It will be valuable in helping us meet your child's individual needs.