Beyond Limits Pediatric Therapy Center, LLC
Admissions Form

Services Requested: OT_____PT_____ST_____

Child's Name:_____Nickname: _____

DOB:_____Diagnosis:_____Gender:_____Male____Female

Address:_____City:_____ST:_____Zip: _____

Name of Parent(s)/Guardian: _____

Home Phone: _____

Mom Cell Phone:_____Dad Cell Phone: _____

Mom Work Phone:_____Dad Work Phone: _____

Mom Employer:_____Dad Employer: _____

Mom Email:_____Dad Email: _____

I consent to be contacted by (please circle all that apply): email text home phone cell phone work phone

Person to Contact in Case of Emergency

Name:_____ Relationship: _____

Home Phone:_____Work Phone:_____Cell: _____

Transport to Which Hospital in Case of Emergency: _____

Physician:_____Phone: _____

Primary Insurance:_____Policy Numbers: _____

Insurance Phone:_____Employer: _____

Policy Holder:_____Relation to Patient: _____

Policy Holder Date Of Birth:_____SS#: _____

Secondary Insurance:_____Policy Numbers: _____

Insurance Phone:_____Employer: _____

Policy Holder:_____Relation to Patient: _____

Policy Holder Date Of Birth:_____SS#: _____

_____ _____

Patient Name DOB

I hereby authorize Beyond Limits Pediatric Therapy Center (BLPTC) to obtain records from other sources as may be required in the treatment of this patient, to release information concerning this patient's treatment to other professionals involved in the care and treatment of this patient, and to release information to the insurance company as needed to file for charges incurred by this patient. I hereby authorize BLPTC to release to all Insurance Companies only such therapeutic and financial information as may be necessary to determine benefits entitled and to process payment claims for therapy services that will be provided.

I also agree that by signing this form, I authorize BLPTC to release information concerning this patient to all persons whose names are listed above on page 1. I hereby authorize payment of insurance benefits otherwise due to me to be made directly to BLPTC.

I understand that I am responsible for all charges incurred. A copy of this authorization shall be as valid as the original.

Concerning "divorce" or "custody" arrangements, BLPTC regards the adult party who signs below as "Parent or Responsible Party" to be the responsible guarantor for that patient's account in all cases and without exception.

I also understand that it is the responsibility of the custodial party to obtain all referrals and that BLPTC is not responsible for obtaining any referrals.

_____ _____ _____

Parent or Responsible Party **Relationship to Patient** **Date**

HIPAA Consent and Disclosure- Privacy Notice Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. We understand that his or her medical information is personal to you, and we are committed to protecting that information. As our client, we create medical records about your child's health, our care for him/her, and the services we provide for your child. By law, we are required to make sure that your child's protected health information is kept private.

By signing this form, you consent to our use and disclosure of protected health information about your child for treatment, payment and health care operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge that the Beyond Limits Pediatric Therapy Privacy Notice (Revision Date, April 1, 2014) has been made available to me. A paper copy of this Notice will be provided any time at my request. This Notice is also displayed in our office and on the Beyond Limits Pediatric Therapy Center website www.beyondlimitstherapy.org

Parent Or Guardian's Printed Name: _____

Parent or Guardian's Signature:_____ Date:_____

Consent for Treatment and Other Acknowledgements

I,_____(parent/guardian), knowing that_____(child's name) has a diagnosis that may benefit from physical, speech, or occupational therapy treatment, voluntarily consent to such care for the aforementioned child by the therapist doing business for Beyond Limits Pediatric Therapy Center as may be beneficial in the professional judgment of my child's therapist. I consent to care and treatment that falls within the scope of practice as defined by the State of Georgia for each discipline.

I understand that treatment will involve physical participation on the part of the patient, which may involve risks of injury. I acknowledge that I am responsible for making my therapist (s) aware of any changes in my child's physical or mental status. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment. I acknowledge that Beyond Limits Pediatric Therapy Center is a teaching facility and supervised students or volunteers may participate in my child's treatment session. I release Beyond Limits Pediatric Therapy Center, its therapists, students, staff and independent contractors from any liability for any accident or injury that is not directly caused by the negligence of Beyond Limits Pediatric Therapy Center or its employees.

In my absence, I consent that _____(child's name) may receive therapy under the care of: _____
(List all caregivers, teachers, daycare providers, etc. that may be present during therapy in your absence.)

INDEPENDENT CONTRACTORS: Beyond Limits Pediatric Therapy Center may utilize independent contractors for evaluations and therapy sessions. These include, but are not limited to, speech therapists, occupational therapists, physical therapists, students and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of Beyond Limits Pediatric Therapy Center and are responsible for their own actions. I understand that Beyond Limits Pediatric Therapy Center shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by Beyond Limits Pediatric Therapy Center.

By signing this document, I certify that I have read and understand its contents.

_____ _____

Patient/Parent/Guardian/Authorized Representative Date

Authorization and Release to Photograph or Videotape

Beyond Limits likes to use pictures/videos of students/clients in our website, brochures, invitations, slideshows, educational, and other programs. This form allows or prohibits Beyond Limits Pediatric Therapy Center to use your child's picture or videotape for marketing, educational or other purposes**. Please select an option and initial next to your selection.**

_____Yes, I give permission for my child to be photographed and/or videotaped. My child's first name may be used; however, if my child is to be identified by first and last name, I must be notified in advance to give express approval prior to publication.

_____No, please do not use pictures of my child for anything outside of the center.

Parent's Printed Name: _____

Parent's Signature: _____ Date: _____

I understand and acknowledge that Beyond Limits Pediatric Therapy Center may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.

Parent's Printed Name: _____

Parent's Signature:_____ Date: _____

BEYOND LIMITS PEDIATRIC THERAPY CENTER
AUTHORIZATION FOR STUDENT OBSERVATION

Beyond Limits is a teaching facility that allows students to observe our therapists and treatment of patients for school requirements. No information will be shared outside of the therapy session. **Please select an option and initial next to your selection.**

_____ Yes, I authorize students to observe my child's therapy sessions at Beyond Limits Therapy per HIPAA guidelines. I have the right to revoke this agreement at any time by providing written notice prior to the therapy session.

_____ No, I do not authorize students to observe my child's therapy sessions at Beyond Limits Therapy.

Child's Name: _____

Parent's Printed Name: _____

Parent's Signature: _____ Date: _____

Beyond Limits Pediatric Therapy Center

Financial and Insurance Policy

Insurance information will be needed before services begin to verify benefits. A copy of your insurance card(s) and driver's license is required. Benefits will be verified upon receipt of your insurance information and you will be made aware of any estimated out-of-pocket expenses. Information gained from insurance companies during verification of benefits is an estimation only and is not guaranteed. I acknowledge that Beyond Limits Pediatric Therapy Center will attempt to obtain or confirm benefits and coverage information from my insurance company or other third party payer, but that this is not a guarantee of coverage or payment, nor does it release me from any payment obligation for the services that I receive. I acknowledge that it is my responsibility to notify Beyond Limits Pediatric Therapy Center of any changes in insurance or Medicaid coverage prior to receiving treatment. If I fail to notify Beyond Limits Pediatric Therapy Center of any change in coverage and services are denied or non-covered, I will be responsible for the full amount of charges for services rendered.

_____parent initials

In return for services to be provided by Beyond Limits Pediaatric Therapy Center, I promise to pay for services rendered by Beyond LimitsPediatric Therapy Center to my child or for my child's benefit. If the services I receive from Beyond Limits Pediatirc Therapy Center are covered by a third party payor, Beyond Limits Pediagric Therapy Center may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services.

_____parent initials

It is imperative that families are aware of their insurance coverage and their potential responsibilities. We will strive to keep open communication in regards to insurance and payment. If you do not have insurance coverage for therapy services a payment plan may be arranged. Payment for private pay sessions is due at the time of service. Please check with the office to verify the in-network insurance providers at this time. All other insurances will be billed as out-of-network. Unless your child has Medicaid, families are responsible for all co-pays, co-insurances, and any deductible at the time of service. If you utilize out of network benefits, payments are due at time of service. As a courtesy will file out of network benefits for private insurance plans by request only and reimbursements will be paid directly to you.

_____parent initials

Primary insurance will always be billed first and Medicaid will be billed secondary unless it is the primary source of payment. Prior authorizations may be required for therapy services. Beyond Limits Pediatric Therapy Center will submit for prior authorizations based on need. Services will be administered after approval has been obtained.

_____parent initials

If a family does not pay a bill within 30 days of receipt, there will be a 10% late fee added.

_____parent initial

As in all health-care situations, the client-family is always responsible for payment when all other sources have been exhausted. Therapy services may be put on hold or terminated if there is a problem regarding payment. There is a $39 service fee for all returned checks. Please do not hesitate to contact us regarding questions of billing/payments. We are willing to work with each client to ensure a balance between providing therapy services and addressing business issues or concerns. I have read and understand the above billing policy.

_____parent initial

CONSENT FOR PAYMENT

I authorize Beyond Limits Pediatric Therapy Center to bill my insurance company for direct reimbursement of therapy services rendered to my child and authorize release of any medical information necessary to process the claim. I assign benefits for filed claims to be paid to Beyond Limits Pediatric Therapy Center and will turn over any payments sent directly to me by my insurance provider that were intended to cover the therapy services provided by Beyond Limits Pediatric Therapy Center. I understand that I am responsible for payment of any services not paid or paid in full by insurance.

_____parent initial

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

_____ _____

Patient/Parent/Guardian/Authorized Representative Date

ATTENDANCE POLICY

Beyond Limits Pediatric Therapy Center policy states that we require a 24- hour notice for cancellations. After a one-time occurrence, a $25 fee may be charged for each missed therapy appointment.

We know that sickness occurs; therefore, if you think that your child is sick the night before, please call us and give us notice so we can plan accordingly. If your child is fine the next day, we will make every effort to reschedule. In the event of a cancellation, please make an effort on your part to reschedule as we want your child to benefit from his/her therapy.

If your child misses 2 consecutive weeks of therapy, we will make every attempt to hold their standing appointment time, but cannot guarantee this with an extended absence. If you have 2 no shows, your child will be removed from the schedule and will be seen on a call in basis. It will be your responsibility to call us for availability if you would like your child seen for therapy.

Beyond Limits Pediatric Therapy Center strives to meet the scheduling needs of every family. If your therapy time does not work for you, please let us know.

The Board of Health considers the following signs to indicate communicable disease/illness:

- Vomiting
- Fever over 100 degrees
- Diarrhea
- Sore throat
- Rash /Swelling
- Red, or running eyes

Please be sure your child is symptom free for 24 hours before resuming therapy.

Signed:_____Date: _____
Parent/Legal Guardian

Beyond Limits Pediatric Therapy Center
Consent to Obtain Information

Child's Name: _____ Date of Birth: _____

To help us better serve your child it is very important that we have access to previous evaluations and other relevant information about your child. Please send copies of the reports along with this packet. If you would like us to contact an outside associate and ask them to fax information directly to Beyond Limits, please provide us with a name, telephone and/or fax number.

Check any of the following professionals your child has been evaluated by:

_____Dev. Pediatrician _____Occupational Therapist _____Neurologist
_____Speech Therapist _____Psychologist _____Orthopedist
_____Audiologist _____Physical Therapist
_____Other: _____

Detail any of the following agencies that have pertinent information to share:

Agency	Contact Name	Phone	Fax

I hereby give permission to release my child's health/ medical/ psychological/ educational/ early intervention/ therapeutic records to Beyond Limits and to discuss my child's care or treatment with appropriate professional staff. I understand that information in my child's records will not be released to any other individual without my specific written consent.

Parent's Printed Name: _____

Parent's Signature: _____ Date: _____

BEYOND LIMITS PEDIATRIC THERAPY CENTER

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

PATIENT NAME: _____ DOB:_____
Address: _____
_____

A) I authorize BLPTC to RELEASE my child's medical records to:
Name: _____
Address: _____
State & Zip: _____
Phone: _____ Fax: _____

B) I authorize BLPTC to OBTAIN my child's medical records from:
Name: _____
Address: _____
State & Zip: _____
Phone: _____ Fax: _____

Please check information that may be released. (Please note that only records that have been ordered by our office will be released.)

_____ All records (will include Audio, ST and OT Evaluations, Plans of Care and Office Notes)
_____ Evaluations
_____ Plans of Care
_____ Office Notes

These records are to be:

_____ Picked up – Please sign for receipt of records: _____
_____ Mailed to: _____
_____ Faxed to: _____
_____ Emailed to: _____
(I acknowledge that I am aware that the email provider is not considered a HIPAA approved secure email provider.)

I hereby authorize this practice to release my medical records, including, but not limited to all of the above. By signing this consent, I completely release the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. I also understand this authorization is only valid for 12 months. However, I reserve the right to revoke this authorization at any time.

SIGNED: _____ DATE: _____

_____ _____
Printed Name Street Address

_____ _____
relationship to patient City, State, Zip Code

_____
contact number

WITNESS: _____ DATE: _____

_____

Beyond Limits Pediatric Therapy Center
Medical History

Patient Name:_____Date of Birth: _____

Pregnancy / Delivery

Pregnancy Proceeded

- ☐ Without Complications
- ☐ With Complications
- ☐ Toxemia
- ☐ Positive for Strep B
- ☐ Gestational Diabetes
- ☐ Premature Labor
- ☐ Multiple Births
- ☐ Substance Exposure
- ☐ Positive for Cytomegalovirus (CMV)

Other _____

Length of Pregnancy (in weeks)_____

Prenatal Care was Received____Not Received _____

Delivery Proceeded

- ☐ Without Complications
- ☐ With Complications
- ☐ Abruptio Placenta
- ☐ Prolapsed Cord
- ☐ Breech Presentation
- ☐ Transverse Presentation
- ☐ Vacuum
- ☐ Umbilical Cord Wrapped Around Neck
- ☐ Placenta Previa
- ☐ Use of Forceps
- ☐ Premature Rupture of Membranes
- ☐ Uterine Rupture
- ☐ Meconium Aspiration

Other _____

Delivery was

- ☐ Vaginal
- ☐ C-Section
- ☐ Emergency C-Section

Birth Weight_____Birth Height_____Apgar 1 min____5 min____10 min ____

Comments:

_____

_____

Following Birth

- ☐ Anemia of Prematurity
- ☐ IVH Bleed Grade IV
- ☐ Brohopulmonary Dysplasia (BPD)
- ☐ Necrotizing Enterocolitis (NEC)
- ☐ Cleft Lip
- ☐ Neonatal Hypoxia
- ☐ Cleft Palate
- ☐ Oxygen Dependency
- ☐ Club Foot
- ☐ Patent Ductus Arteriosus (PDA)
- ☐ ECMO # of Days _____
- ☐ Repiratory Distress Syndrome (RDS)
- ☐ Failure to Thrive
- ☐ Respiratory Synctial Virus (RSV)
- ☐ Hyperbilirubinemia
- ☐ Retinopathy of Prematurity (ROP)
- ☐ Intrauterine Growth Retardation (IUGR)
- ☐ Ventilator Dependency # of Days _____
- ☐ IVH Bleed Grade I
- ☐ VP Shunt
- ☐ IVH Bleed Grade II
- ☐ VH Bleed Grade III

Other _____

Diagnosed or Suspected Syndromes

_____

_____

Health Issues / History

- ☐ Anoxic Brain Injury
- ☐ Constipation / Diarrhea
- ☐ Arteriovenous Malformation (AVM)
- ☐ Reflux
- ☐ Asthma / Respiratory
- ☐ Seizure Disorder
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Sleep Problems _____
- ☐ Chronic Ear Infections
- ☐ Traumatic Brain Injury (TBI)
- ☐ Colic
- ☐ Tube Feeding
- ☐ Cardiac Condition
- ☐ Allergies

Other: _____

Current Medications

_____

_____

Current Vitamins, Herbs, Minerals, Homeopathic

_____

Hearing Test

- ☐ Never Tested
- ☐ No Concerns
- ☐ Never Tested, Have Concerns _____

Test Results Date_____Results _____

Specialists Seen_____

Vision Test

- ☐ Never Tested
- ☐ No Concerns
- ☐ Never Tested, Have Concerns _____

Test Results Date_____Results _____

Specialist Seen		
	Name	Reason
Allergist		
Cardiologist		
Developmental Medicine		
ENT		
Gastroenterologist		
General Surgeon		
Geneticist		
Neuro-Surgeon		
Neurologist		
Orthopedic Surgeon		
Physiatrist		
Psychologist		
Rheumatologist		

Diagnostic Tests		
	Date	Result
ABR / BAER		
Blood Work / Lab Test		
CT Scan		
EEG		
EMG		
Motility Study / Empty Scan		
MRI		
Swallow Study		
X-Ray		

Allergy Testing		

Surgeries and Procedures

Type	Date	Age	Results

Contraindications / Precautions

- ☐ None
- ☐ Allergies _____
- ☐ G-tube
- ☐ Vagal Nerve Stimulator
- ☐ Other _____
- ☐ Baclofen Pump
- ☐ Seizure Condition
- ☐ Shunt

Other _____

Medical Conditions

_____

Orthopedic Conditions

_____

Developmental History

Motor / Sensory / Plan			
Milestone	When (in Mths)	Milestone	When (in Mths)
Creeps / Crawls Alone		Holds Head Up Alone	
Rolls Over		Walks Unaided	
Grabs Toys		Pulls Self to Standing	
Sits Alone No Support			

How does child get around the house?

_____

Favorite Toys / Play Activities?

_____

Is your child

☐ Right Handed ☐ Left Handed ☐ Neither

Does child fall or lose balance easily?

☐ Yes ☐ No

Child visually looks at people and/or toys?

☐ Yes ☐ No

Child shows a negative response when touched or when touching other objects?

☐ Yes ☐ No

Child enjoys movement such as swinging or roughhousing?

☐ Yes ☐ No

Child plays and/or participates in leisure activities daily?

☐ Yes ☐ No

Child is involved in community programs (school, special rec., scouts, etc.)?

_____

Speech / Language

Milestone	When (in Months)
Name Familiar Objects	
Stopped Using a Bottle	
Stopped Using a Pacifier	
Use Two-Word Combinations	

Primary Communication

Non-Verbal

- ☐ Body Language
- ☐ Eye Gaze
- ☐ Facial Expressions
- ☐ Manual Sign Language
- ☐ Pointing / Gesturing

Verbal

- ☐ Phrases
- ☐ Single Words
- ☐ Sentences
- ☐ Vocalizations

Feeding - Please only complete the feeding section if you have feeding concerns

Describe Any Feeding Problems / Concerns

_____

Food Likes_____Food Dislikes _____

Feeding Milestone	When (in Months)
Begin Eating Baby Food	
Begin Eating Table Food	
Begin Using a Cup, Sippy Cup, Straw	
Complete Sentences	

Areas of Difficulty

- Chewing
- Drooling
- Transitioning Between Foods
- Swallowing
- Communication Needs
- Understanding Words

Description of Child

- Active
- Curious
- Fearless
- Persistent
- Affectionate
- Demanding
- Fussy
- Aggressive
- Difficult to Comfort
- Insecure
- Shy
- Calm
- Distractible
- Motivated
- Stubborn
- Cautious
- Fearful
- Passive
- Withdrawn

Education

Grade in School_____Name of School _____

Does your child have an IEP from school?

- Yes
- No

Has your child had a psychological or neuropsychological evaluation completed?

- Yes
- No

Therapy Services	Status	Where	Frequency/Duration
Behavior			
Nutrition			
Occupational			
Physical			
Speech / Language			
Social			
Vision			
Feeding			
TEIS			
Developmental Preschool			
Home Devel Instruction			

Person completing form:_____Date completed: _____

Relationship to child: _____