Patient Information

Client Name:	MR #:	Date:

DOB: _____ Sex: M F Social Security #: _____

Street Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Employer: _____

Student?: Y N School: _____

Referring Doctor: _____ Dominant Language: _____

Parent/ Guardian Information

Employer: _____ Phone: _____

Street Address: _____ City: _____ State:_____ Zip: _____

Primary Physician: _____ Phone: _____

Primary Physician's Office: _____

Emergency Contact: _____ Relation: _____

Phone: _____

Primary Insurance: _____

Group #: _____ ID#/Claim #: _____

If policy holder is different than patient:

Policy Holder: _____ DOB: _____ SSN: _____

Sex: M F Relation to client: _____

Street Address: _____ City: _____State: _____ Zip: _____

Client release & insurance authorization (Please initial):

_____ I hereby authorize payment directly to the center for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to them, but not to exceed the physician's and/or the institute's regular charges for therapy for this treatment period.

_____ I further authorize the release of any medical information required by my insurance carrier and/or treating physicians.

_____ I hereby certify that all information on this form is correct to the best of my knowledge.

Notice: Misrepresentation and/or falsification of essential information requested in this document may be subject to monetary fines and/or imprisonment if convicted, under federal law. My signature indicates that I have read and understood the information provided upon my admission to the center. This information includes a consent form, insurance information, and medical release form and insurance benefits assignment/ financial agreement.

Signature: _____ Date: _____

Treatment Plan Agreement

Client Name:	MR #:	Date:

The following is a description of this clinic's policies regarding the treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies, please ask a representative of this clinic before signing.

Non Discrimination Policy
The center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, and activities, or in employment.

_____
Initials

Scheduling Policy and Consent to Treat
I, the patient, Parent of Legal Guardian, hereby consent to treatment for therapy services. I further understand that once a weekly treatment appointment has been determined, this clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advanced notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapists as well.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that I have up to two weeks from the time of cancellation to make up for the cancelled session; I understand that I will lose the cancelled session if not made up within two weeks. I understand that a makeup session may occur with this clinic's substitute therapist or regular therapist with this clinic and may be offered as a separate session or by adding on additional time to several sessions.

I understand that notification of vacations or family obligations is requested at least two sessions prior to the expected absence, to facilitate rescheduling our appointment(s). I understand that we are entitled to make up sessions for vacation time two weeks before or following our vacation time.

I understand that the clinic is open Monday-Thursday except in cases of severe weather and holidays. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and is the opening of the clinic has been delayed. Families may cancel treatment if they do not wish to travel in poor conditions.

I understand that if our therapist is ill or on vacation, the clinic will provide a substitute therapist to ensure continuation of services. This clinic will make every effort to schedule the therapist at our regularly scheduled appointment time. If this cannot occur, the clinic will provide an alternate appointment time.

I understand that if we do not keep a scheduled appointment or if we do not cancel a session before the session is scheduled to begin, that time of treatment is forfeited.

I have read and agree to abide by the above policies.

_____ _____
Signature of Parent or Legal Guardian **Date**

Client Name:	MR #:	Date:

Office Policy for Families with Child Clients
Parents or caregivers are invited to participate in the clients' evaluation/treatment session as space permits. Other children must be supervised by a parent or caregiver at all times.

_____
Initials

I understand that there is some inherent risk associated in the use of therapeutic equipment at this clinic, and I agree to indemnify and hold the clinic harmless of any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment.

_____
Initials

Coordination of Care
I give permission to have this clinic contact and discuss my child's case with all persons whose names I have provided as professionals working with my child.

_____
Initials

I give permission for this clinic to send copies of progress reports to all referral sources whose names I have provided.

_____
Initials

Teaching and Education of Students
I give permission for speech therapy students to observe my child's therapy. I understand that I will be notified before such an observation takes place.

_____
Initials

Consent Photograph
I give permission for photographs/videotapes to be taken of myself or my child for educational and/or promotional purposes. I understand that any photographs or videotapes will be reviewed by me before they are released.

_____
Initials

_____ _____
Signature of Parent or Legal Guardian **Date**

Client Responsibilities

Client Name:	MR #:	Date:

Purpose:
To inform the clients of their responsibilities as a participant in the total care process.

Policy:
All clients are responsible for:

1. Behavior that shows respect and consideration for other clients, family, visitors, and personnel of the clinic.
2. Assuring that the financial obligations for healthcare rendered are paid in a timely manner.
3. Accepting consequences of their actions if they should refuse a treatment, or if they do not follow or understand that instructions given to them by the doctor or their healthcare team member.
4. Providing the clinic to the best of their knowledge with accurate and complete medical history about present complaints, past illnesses, hospitalizations, surgeries, and existence of medications and other pertinent data.
5. Following the plan of care recommended by the doctor primarily responsible for the client's care and/or other personnel authorized by the clinic to so instruct clients.
6. Notifying the clinic of any change in their condition or circumstances.
7. Keeping their appointment for scheduled services. It they anticipate a delay or must cancel the scheduled service, it is their responsibility to notify the clinic as soon as possible.
8. The safekeeping of their valuable while at the clinic is the responsibility of the client or guardian.

_____ _____

Signature of Parent or Legal Guardian **Date**

Sick Policy Consent

Client Name:	MR #:	Date:

It is the policy of the clinic that in an event that a client becomes ill, the clinic will utilize the following guidelines for re-admitting clients into treatments as listed below:

- Oral temperature of 100 degrees or above
- Vomiting, nausea, or severe abdominal pain
- Marked drowsiness or malaise
- Sore throat, acute cold, or persistent cough
- Red, inflamed, or discharging eyes
- Acute skin rashes or eruptions
- Swollen glands around jaws, ears, and neck
- Any skin lesion in the weeping stage
- Earache
- Head lice
- Diarrhea, runny, watery, or bloody stools
- Other symptoms suggestive of acute illness

Return to Therapy Guidelines:

- Fever free for 24 hours
- Symptoms free of vomiting, nausea, or severe abdominal pain for 24 hours
- Symptom free of marked drowsiness or mailaise
- Symptom free of sore throat, acute cold, or persistent cough
- Treated head lice
- Symptom free from diarrhea, runny, watery, or bloody stools
- All health conditions listed above have been treated and resolved

_____ _____

Signature of Parent or Legal Guardian **Date**

Big Little Words Pediatric Therapy Clinic, Inc.
Medical Records Release/Request Form

(Check One)

- **Release**- Releasing information from us to you or your provider
- **Request**- Requesting information from another provider to us

Date: _____

Name: _____ DOB: _____

Address: _____

City/State/Zip: _____

Phone: _____ SSN: _____

I authorize Big Little Words Pediatric Therapy Clinic, Inc. to release/request (circle one) the following information:

Information requested/ released (circle one): _____

_____

_____

To/From: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

- I understand that this authorization shall be valid through _____ (date), but that I may revoke it in writing at any time; and such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and sopy the information released.
- I understand that if I refuse to consent to disclosure of information, the clinic may be unable to serve me and/or provide the most appropriate care for me.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

_____ _____

Signature of Parent or Legal Guardian **Date**