PILLER
CHILD
DEVELOPMENT

Client Information

Child's Name_____ Date of Birth_____

Address _____

City _____ State _____ Zip _____

Father's Name _____ Phone (home)_____
Phone (cell)_____

Address _____

City _____ State _____ Zip _____

Email _____

Father's Employer _____

Mother's Name _____ Phone (home)_____
Phone (cell)_____

Address _____

City _____ State _____ Zip _____

Email _____

Mother's Employer _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Care Physician _____

Address _____

Phone _____ Fax _____

PILLER CHILD DEVELOPMENT

Developmental/Health History

Who referred your child to therapy? _____

Has your child been given a diagnosis? ☐ yes ☐ no
If yes, what is the diagnosis? _____
Who made the diagnosis? _____

Is your child on any medications? ☐ yes ☐ no
Please list: _____

Birth History

Full Term ☐ yes ☐ no Premature ☐ yes ☐ no If yes, how many weeks?_____

Were there any complications during pregnancy? ☐ yes ☐ no
If yes, please describe.
_____
_____

Were there any complications during labor or delivery? ☐ yes ☐ no
If yes, please describe. _____
_____
_____

Vaginal ___ C-section ___

What was your child's birth weight? ____ lbs ___ oz

Developmental History

At what age did your child: Sit Alone _____ Crawl _____ Walk _____ Say single words _____ Put two words together _____

Has your child had his/her hearing checked? ☐ yes ☐ no
☐ Pass ☐ Did not Pass _____

Has your child had his/her vision checked? ☐ yes ☐ no
☐ Pass ☐ Did not Pass _____

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Medical History

Does your child have a history of or currently experience:

Ear Infections	☐ yes ☐ no	Tube Placement	☐ yes ☐ no
Allergies	☐ yes ☐ no	_____	
Asthma	☐ yes ☐ no	_____	
Vision Difficulties	☐ yes ☐ no	_____	
Hearing Deficits	☐ yes ☐ no	_____	
Seizures	☐ yes ☐ no	_____	
Head Injury	☐ yes ☐ no	_____	
Major Illness	☐ yes ☐ no	_____	
Feeding Problems	☐ yes ☐ no	_____	

Other medical history _____

_____

Has your child been hospitalized? _____ If yes, for what reason?

_____

Social and Academic

Does your child attend school or preschool? ☐ yes ☐ no

If yes, what grade? _____

Does he/she perform at grade level in Reading ☐ yes ☐ no Math ☐ yes ☐ no

Do you have any concerns with social skills? ☐ yes ☐ no If so, please describe

_____

_____

_____

What does your child like to do in his/her free time? _____

_____

Does your child have a favorite toy or something he/she enjoys (e.g. Thomas, cars, etc)? _____

Therapy Goals

What are your goals for therapy? _____

_____

_____

_____

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Speech/Language Parent Questionnaire

Background

What is the child's primary language?_____

Is there more than one language used at home or other environments? ☐ yes ☐ no

Do you feel your child has a speech problem? ☐ yes ☐ no
Do you feel your child has a hearing problem? ☐ yes ☐ no
Is this your child's first speech evaluation? ☐ yes ☐ no
Has your child ever received speech therapy? ☐ yes ☐ no
Is your child aware of his/her speech difficulties? ☐ yes ☐ no
Has anyone else expressed concern regarding your child's speech/hearing (i.e. Grandparents, Teachers) ☐ yes ☐ no

Comments:_____
_____
_____
_____

Expressive/Receptive/Social Speech/Language Skills

How many words does your child produce? _____
Can your child communicate wants/needs/thoughts easily? ☐ yes ☐ no
Does your child imitate: sounds ☐ yes ☐ no
words ☐ yes ☐ no
phrases ☐ yes ☐ no
Does your child request items by name? ☐ yes ☐ no
Does your child point/retrieve items upon request? ☐ yes ☐ no
Does your child follow simple directions (i.e. "sit down" "go get your shoes and bring them to me.") ☐ yes ☐ no

If your child is school-age, can he/she follow multiple step directions (i.e. "get out your paper, write your name at the top, and put your pencil down.) ☐ yes ☐ no

Does your child respond appropriately to yes/no and "wh" questions? ☐ yes ☐ no

Can your child communicate effectively with his/her peers and/or people in environments other than the home? ☐ yes ☐ no

Comments: _____
_____
_____
_____

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Insurance Information

Primary Insurance Company_____

Policy Holder _____ Employer _____

Relationship to Patient _____ Date of Birth _____

ID or Policy # _____ Group # _____

Was your insurance plan purchased on the Healthcare Marketplace? ☐ yes ☐ no

Secondary Insurance Company_____

Policy Holder _____ Employer _____

Relationship to Patient _____ Date of Birth _____

ID or Policy # _____ Group # _____

Medical Information Release
I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies, third party payers, or other health care agencies. A photocopy of this assignment is considered as valid as the original. I also authorize the release of medical records or copies of such and request that they be transferred to Piller Child Development, LLC,

Assignment of Benefits
I request that payment of authorized insurance benefits be made on my behalf to Piller Child Development, LLC.

Signature _____ Date _____

Consent for Care
I, the undersigned, to hereby agree and give my consent for Piller Child Development to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition.

Signature _____ Date _____

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

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Payment and Cancellation Policy

Payment Policies
Piller Child Development, LLC does everything possible to minimize the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is summary of our payment policy.

All payment is expected at the time of service
Payment is required at the time services are rendered. We have a contractual obligation (with your insurance company) to collect all co-pays and co-insurance. This includes applicable co-payments for participating insurance companies. Payment will be collected when you check in. We are unable to bill co pays to you or secondary insurances.

Outstanding Balance
Once payment is received from your insurance company, you will be billed for any remaining amount. Payment for outstanding balances is expected within 10 business days. Patients with an outstanding balance of 30 days overdue must make arrangements for payment prior to scheduling appointments. We realize that people have financial difficulty. Please communicate with our billing and collection staff so that they may assist to create a financial plan with you. If your account becomes delinquent by more than 60 days, we will be forced to forward it to a collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee we charge you will be equal to the amount that the collection agency charges us. You will be responsible for paying the full balance, including this fee. A fee of $25 will be applied to each returned check.

Insurance
We bill participating insurance companies as a courtesy to you. You are expected to pay your deductibles and co-payments at the time of service. If we have not received payment from your insurance company, you will be expected to pay the balance in full. **You are responsible for all charges.** Insurance cards must be provided at your first appointment. If your insurance company requires you to have a referral or authorization for therapy, please verify with our front office that a current referral or authorization is on file. Our office will put forth as much effort as possible to help obtain these documents, however, the **patient is ultimately responsible for any resulting costs that may be associated with your visits.**

Missed Appointments /Cancellations
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24-hours notice to avoid charge. Cancellations with less than 24 hour notice, short notice reschedule, or "no shows" will be subject to a $35 fee. "No show" on Saturday appointments are subject to a $50 fee. If you have more than 2 cancellations within a 4-week period or 2 or more "no shows," we reserve the right to discontinue services. If more than 15 minutes late to an appointment, we reserve the right to charge a late appointment fee of $15.

_____ *Initials*

Refunds
Overpayments will be refunded upon written request to the responsible party within 30 days of our office confirmation. Otherwise, overpayments will be applied as a credit to your account.

Financial Policy
I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance.

I agree to the terms of the payment and cancellation policy. My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

Signature_____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received a copy of Piller Child Development's Notice of Privacy Practices.

_____ _____
Parent or legal guardian signature Date

_____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)

I authorize and agree that Piller Child Development may disclose my protected health information to the following persons, each of who is directly involved in my care: (Please list pcp, and other doctors or therapists that you would like to receive copies of reports)

Name	Relationship to Child	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge and agree that Piller Child Development may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Piller Child Development.

Piller Child Development may contact me via the following manners:

Phone	☐ yes ☐ no	Leave Message	☐ yes ☐ no
Text Message	☐ yes ☐ no		
Email	☐ yes ☐ no		

_____ _____
Signature Date

_____
Printed Name

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ **Date of Birth:** _____

Parent Name: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider Piller Child Development, LLC to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information either in writing or verbally

_____

Fax _____ Phone _____

Purpose: I understand that the specific purpose of this Authorization is

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

- ❑ All therapy records
- ❑ Evaluation only
- ❑ All therapy records except: _____

Term: This Authorization will remain in effect until _____.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____ _____

Parent/Guardian Signature Date

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.