Client Information

Child's Name____ Date of Birth____________

Address ____

City _________________________ State ______ Zip _____________

Contact Email _____________________________________

May we email you? ❑ yes ❑ no

Primary Phone _________________________

Alternative Phone __________________________

May we leave a message? ❑ yes ❑ no

Father's Name ______________________________________

Address ____

City _________________________ State ______ Zip _____________

Father's Employer ____

Mother's Name _____________________________________

Address ____

City _________________________ State ______ Zip _____________

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 received therapy in the past? ☐ yes ☐ no
☐ Speech therapy ☐ Occupational therapy ☐ Physical 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 ____ Toilet Trained ____
Babbled ____ 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 ____

Medical History

Does your child have a history of or currently experience:

Ear Infections ☐ yes ☐ no Tube Placement ☐ yes ☐ no
Adeniodectomy ☐ yes ☐ no Tonsillectomy ☐ 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

Who resides in the child's home? ____
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
Does your child currently have an Individualized Education Plan (IEP) and/or receiving special services? ❑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? ____
____
____
____

PILLER CHILD DEVELOPMENT

Speech/Language Parent Questionnaire

What is the child's primary language? ____

Is there more than one language spoken in the home? ❑ yes ❑ no

____

Is there a family history of speech and language difficulties? ❑ yes ❑ no

Please explain: ____

Is there a family history of learning disabilities or learning difficulties? ❑ yes ❑ no

Please explain: ____

Does/Did your child…

❑ String sounds together or make word approximations? (i.e. "bababa"; "bup" for "cup")

❑ Repeat scripted phrases? (i.e. repeat phrases from movies or shows out of context)

❑ Imitate sounds/words after given a verbal model? (i.e. Parent says "bubble", child imitates "bubble" or "bubbo")

❑Retrieve or point to common objects? (i.e. give me the ball)

❑ Have difficulty learning letters, numbers, or colors?

❑ Follow simple directions? (i.e. go sit down)

❑ Understand the concept of yes/no?

❑Respond appropriately to 'wh' questions? (i.e. "Where is the ball?" "What is the boy doing?")

❑ Have difficulty producing specific sounds? (i.e. "tup" for "cup")__________________

❑ Demonstrate dysfluent speech? (i.e. stuttering - "ba-ba-ba-ball"; "I -uh want -uh ball")

❑ Have difficulty understanding what he/she reads?

❑ Have difficulty with writing? (i.e. generating narratives, spelling, writing conventions)

Your child currently communicates using…

❑ body language/facial expressions

❑ sounds (vowels, grunting)

❑ words (ball, go, more)

❑ 2-4 word phrases (i.e. "more ball", "I want juice")

❑ sentences longer than four words (i.e. "She is sitting on the chair")

❑ other (sign language, AAC device, picture exchange) __________________________

Please explain any other speech and language concerns you may have:

____

____

____

Insurance Information

Primary Insurance Company____

Policy Holder ____________________________ Employer ______________________

Relationship to Patient ____________________________ Date of Birth _____________

ID or Policy # _______________________________ Group # _______________

Marketplace plan ☐ 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.

Payment/Cancellation/Participation Policy for Client Receiving Services through the Division of Developmental Disabilities

Missed Appointments /Cancellations/No Shows
Missed appointments represent a cost to us and other patients who could have been seen in the time set aside for you. Patients are asked to give 24-hours notice. If a patient has more than 2 cancellations within a 4-week period or 2 or more "no shows," the patient is subject to loose their scheduled time and will need to find another time on the schedule that is more conducive to meet their needs. However, if a patient has 2 or more "no shows" or more than 2 cancellations in a 4 week period they are subject to loosing their spot on the schedule and need to find a new time for services. In addition, the support coordinator will be notified to help ensure the client is receiving services and resolve any issues that may arise.

Insurance

We bill participating insurance companies. DDD is a payer of last resort. Therefore, we bill your primary and secondary (if applicable) insurance before billing DDD. You are required to notify Piller Child Development of any changes in insurance coverage as soon as the change occurs. Updated insurance cards, photo identification, and script for services are required for all clients.

Parent Participation

It is essential that family/caregiver training be an ongoing part of the therapy process. Parents/caregivers are encouraged to participate in therapy sessions to ensure carryover with the treatment plan in environments outside of the clinic setting. Parents are provided with specific home program recommendations which are followed up on and adjusted at each session. Therapist are to provide home program recommendations that fit the needs of the family structure. Techniques used in therapy and home program recommendations can be provided in a variety of formats including demonstration, written, or verbal. All parent participation and home programs should be documented in the patient chart. Caregivers and parents of clients receiving services through DDD must remain in on the premise at all times during the child's therapy session. Parents are encouraged to be an active participant within the therapy session. This allows the therapist and caregiver to work closely together to ensure carry over in various environments.

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Location of Services

I understand that all services with DDD performed through Piller Child Development must be performed at the Mesa location. No other Piller Child Development location is certified to perform services through the Department of Developmental Disabilities. All LTC insurance through DDD will not be accepted at any other Piller Child Development.

I understand and agree to the above policies.

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**________________________

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.

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.