PILLER
CHILD
DEVELOPMENT DDD

## Client Information

Child's Name _____
First Middle Last

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 _____

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## 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 Date of Test _____

Has your child had his/her vision checked? ☐ yes ☐ no
☐ Pass ☐ Did notPass Date of Test _____

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**Medical History**

Does your child have a history of or currently experience:

Ear Infections ☐ yes ☐ no
Adeniodectomy ☐ 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

Tube Placement ☐ yes ☐ no
Tonsillectomy ☐ 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? _____
_____
_____
_____

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## Insurance Information

**Primary Insurance Company**_____

Policy Holder _____ SS Number _____

Relationship to Patient _____ Date of Birth _____

Employer _____

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 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. Failure to provide changes in insurance, scripts for therapy services, and other required documentation may result in a delay or cancellation of services until required documents are received.

**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.

***continued on next page***

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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.

_____ _____

**Parent/Guardian 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 and patient rights.

☐ I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_____ _____
Parent or legal guardian signature Date

Due to the HIPPA laws now in effect we must have detailed information as to whom we may release medical information. Please read and check the appropriate areas as you see fit. This release is valid until you notify us in writing otherwise.

To whom may we release your medical, financial, and billing information?

| Name | Relationship to Child |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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.

_____ _____
Parent or legal guardian 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

PILLER
CHILD
DEVELOPMENT DDD

**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.