

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 _____

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 not Pass Date of Test _____

Medical History

Does your child have a history of or currently experience:

Ear Infections	<input type="checkbox"/> yes <input type="checkbox"/> no		Tube Placement	<input type="checkbox"/> yes <input type="checkbox"/> no
Adeniodectomy	<input type="checkbox"/> yes <input type="checkbox"/> no	Tonsillectomy	<input type="checkbox"/> yes <input type="checkbox"/> no	
Allergies	<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Vision Difficulties	<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Hearing Deficits	<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Head Injury	<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Major Illness	<input type="checkbox"/> yes <input type="checkbox"/> no		_____	
Feeding Problems	<input type="checkbox"/> yes <input type="checkbox"/> 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? _____

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 _____ 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 losing 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.

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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



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.

- 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	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.

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

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.