RIVERWALK
pediatric THERAPY
SPEECH • OCCUPATIONAL • PHYSICAL

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PEDIATRIC HISTORY FORM

Date: _____

Child's Name: _____ Date of Birth: _____

Please answer all the questions listed below to assist us in planning a program specific to your child. All information is kept confidential as part of your child's medical record.

MEDICAL HISTORY

1) Number of weeks gestation your child was born: _____ Birth Weight: _____

2) This is my ☐ Natural Born Child ☐ Adopted Child

   a. Were there any prenatal complications such as illness, injury, bleeding, bed-rest, etc.? *If yes please explain.*

      ☐ Yes _____
      ☐ No

   b. What was your method of delivery? ☐ Vaginal ☐ C-Section

   c. Were forceps or suctions used during delivery? ☐ Yes ☐ No

   d. Were there any complications during delivery? *If yes, please explain.*

      ☐ Yes _____
      ☐ No

   e. Did your child have any injuries at birth? *If yes, please explain.*

      ☐ Yes _____
      ☐ No

   f. Was oxygen or respiratory assistance required for your child after birth? *If yes, please explain.*

      ☐ Yes _____
      ☐ No

   g. Did your child require a stay in the NICU after birth? *If yes, please explain.*

      ☐ Yes _____
      ☐ No

   h. Did your child experience any difficulties with feeding as an infant? *If yes, please explain.*

      ☐ Yes _____
      ☐ No

Child's Name: _____ Date of Birth: _____

3) Does your child have a diagnosis? *If yes, please indicate diagnosis below.*

☐ Yes _____

a. Who diagnosed your child? _____

b. What date did your child receive this diagnosis? _____

☐ No

4) Does your child have any allergies (food and/or environmental)? *If yes, please list below.*

☐ Yes _____

a. If yes, do these allergies require an Epi-Pen? ☐ Yes ☐ No

☐ No

5) Is your child currently taking any medications? *If yes, please list below.* ☐ Yes ☐ No

Medication Name	Date Started	Dosage

6) Does your child have any health complications that could impact services? *If yes, please explain.*

☐ Yes _____

☐ No

7) Is there a significant family history that has the potential to have an impact on your child's services? *If yes, please explain.*

☐ Yes _____

☐ No

8) Are your child's immunizations up to date? *If not, please explain.*

☐ Yes

☐ No _____

9) Is your child currently complaining of pain? ☐ Yes ☐ No

a. If yes, is the pain ☐ Intermittent ☐ Constant

10) Do you feel your child is a fall risk? If yes, please describe during what situations you feel your child is at the greatest risk for falls.

☐ Yes _____

☐ No

11) Does your child have seizures? *If yes, please describe the type and frequency of the seizures.*

☐ Yes _____

☐ No

Child's Name: _____ Date of Birth: _____

12) Has your child been involved in any serious accidents? *If yes, please explain.*

☐ Yes _____
☐ No

13) Please indicate if there are any conditions or surgeries for which your child has been hospitalized or treated for.

Condition/Surgery	Date

14) Please indicate what specialists as well as the name of the doctor(s) your child is being seen by:

☐ Cardiologist ☐ Gastroenterologist ☐ Neurosurgeon
☐ Orthopedist ☐ Chiropractor ☐ Ophthalmologist
☐ Ear, Nose & Throat Specialist ☐ Psychologist/Psychiatrist ☐ Neurologist
☐ Rheumatologist ☐ Developmental Pediatrician
☐ Other (explain)_____

15) Does your child wear glasses? *If yes, please specify if they are for reading, distance, or both.*

☐ Yes _____
☐ No

16) Do you have any concerns with your child's hearing? *If yes, please explain.*

☐ Yes _____
☐ No

17) Has your child ever had a hearing screening done (not including the newborn hearing screen)? *If yes, please provide the date and results.*

☐ Yes _____
☐ No

18) Has your child ever had PE tubes placed in his/her ears?

☐ Yes, Date they were placed: _____ Are they still in place? ☐ Yes ☐ No

☐ No

19) Are there any other precautions that we should be aware of when providing services to your child?

_____

_____

_____

Child's Name: _____ Date of Birth: _____

SOCIAL HISTORY

1) Does your child utilize any of the following specialized equipment? (Check all that apply)

☐ Eye Glasses	☐ Hearing Aides	☐ Bath Chair
☐ Stander	☐ Walker	☐ Adapted Toilet Seat
☐ AFO's	☐ Specialized Stroller	☐ Wheelchair: Manuel or Power
☐ Cane	☐ Crutches	☐ Splits/Braces for Upper Extremities

☐ Other (explain)_____

2) Is your child involved in any community activities? *If yes, please list them below.*

☐ Yes _____

_____

_____

☐ No

3) Please list all current therapies your child is participating in. (This includes both outpatient and educational based therapies)

_____

_____

_____

_____

4) What school does your child currently attend? _____

   a. What grade is your child in? _____

      ☐ Regular Education
      ☐ 504 Plan
      ☐ Special Education

   b. Please list any accommodations that are currently being made for your child in school:

_____

_____

_____

_____

_____

_____

_____

Child's Name: _____ Date of Birth: _____

FUNCTIONAL HISTORY

1) What everyday tasks are difficult for your child? *(Check all that apply)*

☐ Bathing	☐ Grasping Objects	☐ Sleeping
☐ Climbing Stairs	☐ Reaching for Objects	☐ Social Interaction
☐ Communicating	☐ Releasing Objects	☐ Toileting
☐ Dressing	☐ Running	☐ Using Utensils
☐ Self-feeding	☐ Sitting	☐ Walking

2) Please provide any additional details regarding your child's daily routines that are difficulty for him/her to perform.

_____

_____

_____

_____

3) What are some things/tasks your child does well?

_____

_____

_____

_____

4) What are some of your child's preferred activities?

_____

_____

_____

_____

5) What would you like to see your child accomplish during their time in therapy?

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date:_____

Riverwalk Physical Therapy, L.L.C.
CONSENT TO BILL & RELEASE PROTECTED HEALTH INFORMATION

I authorize Riverwalk Physical Therapy to release information necessary for billing my insurance company. If referral(s) is required, I understand that obtaining the referral(s) and keeping track of expirations dates and visit limits is solely my responsibility. It is also my responsibility to provide an IEP, if you have one, – (to be shared with the health insurance company only if needed for reimbursement purposes.)

Your benefit information that we share with you on our "Benefit Verification Form" is only an explanation of coverage obtained from your insurance company and it is not a guarantee of coverage. "I understand that a referral or having a script from my primary care physician is not a guarantee of payment by my insurance company. I assume responsibility for payment of services if denied by my insurance company. I will pay my co-payment/co-insurance at the time of service. I understand that **any fees not paid by my insurance company will be billed to me."**

I understand that evaluations consist of an initial consultation, testing if necessary, and a narrative report. Some insurance plans cover only the testing. If this is the case with my insurance, I understand that I am responsible for any non-covered service provided in addition to my co-pay and applicable deductible authorized by my insurance company. Any balance outstanding past 30 days will incur a $25.00 late fee per month.

I understand that if upon retrospective evaluation my insurance company determines that payment was made by them in error or request reimbursement, I will be responsible for said reimbursement.

Please ask questions regarding your insurance policy and payments expected to ensure your full understanding.

I have read and understand this Consent to Bill and Release Protected Health Information Statement:

Parent/Guardian Signature: _____ Date: _____

Riverwalk Physical Therapy, L.L.C.

WAIVER OF LIABILITY

I give permission for my child to participate in Riverwalk Physical Therapy's programs and services. I hereby release Riverwalk Physical Therapy principal owners, therapists, employees, and representatives and all other individuals or organizations acting on behalf of Riverwalk Physical Therapy, from any and all claims which I or my child may have, resulting from or in connection with my child's participation in Riverwalk Physical Therapy programs. This includes, but without limitation, any claim, demands, or causes of action for injuries to my child, including but not limited to injuries resulting from the use of any play/therapy equipment during the program at the Riverwalk Physical Therapy center or at clients' homes.

I understand that I should be present at all times during delivery of service to my child. If I choose not to, I understand that the aforementioned statements still apply in my presence or absence during the services provided. This agreement is signed for the purpose of fully or completely releasing, discharging, and indemnifying Riverwalk Physical Therapy in connection with their programs, staff and facility from all liability as herein described.

I have read and understand Riverwalk Physical Therapy's Waiver of Liability:

Parent/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT)

I hereby acknowledge that I have received a copy of the Notice of "Privacy Practices" for Riverwalk Physical Therapy. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations. I understand that Riverwalk Physical Therapy also serves as a training and research facility and at times other therapists may be observing, handling, or have access to my child's medical information. I authorize Riverwalk Physical Therapy to obtain medical records and/or professional information from my child's physician or other medical professional as it relates to my child's treatment.

I have read and understand Riverwalk Physical Therapy's Notice of Privacy Practices:

Parent/Guardian Signature: _____ Date: _____

Riverwalk Physical Therapy, L.L.C.
PEDIATRIC ATTENDANCE & DISCHARGE POLICY

In order for our therapists to aid in the progress of your child's development, it is important that your child attend all therapy sessions as scheduled and on time. In order to better serve our patients, we have developed the following guidelines.

1. Duration of treatment is an important component of the therapeutic process. Patients are given a prescribed amount of time and are to arrive at the scheduled therapy time every session. If the patient is more than 15 minutes late, the session will be considered a cancelled visit and initiation of therapy will be at the therapist's discretion. **If a patient is more than 15 minutes late three consecutive times, the therapist has the right to discharge the patient.**

   It is equally as important to pick your child up on time. If a caregiver is habitually late picking up their child, the therapist is unable to communicate the Home Exercise Program to the caregiver. Furthermore, the team members at Riverwalk Physical Therapy cannot be responsible for watching your child outside of therapy times. **If a patient is picked up late more than three times, the therapist has the right to discharge the patient.**

2. Frequency of treatment is also an important component of the therapeutic process. Patients are given a prescribed number of days per week based on the findings of their initial evaluation. **We require a minimum of 75% attendance of scheduled sessions per month. The patient may be discharged from the program if this frequency is not met** (e.g., therapy scheduled once a week = one cancellation per month permitted; therapy scheduled twice a week = two cancellations per month permitted, etc.).

3. It is your responsibility to notify the patient care coordinator or therapist if you need to cancel **24 hours in advance of the cancellation.** We are aware that unforeseen events occur that may prevent the 24-hour cancellation; however, please call to cancel. If you do not call to cancel 24 hours in advance, we retain the right to charge a $75 "no cancellation" fee.

4. **If your child is ill, please cancel the therapy session.** Illnesses include – but are not limited to – a fever greater than 99.6°F within a 24-hour period, respiratory (e.g., cough, difficulty breathing) and gastrointestinal symptoms (e.g., vomiting, diarrhea) within a 24-hour period, symptoms of communicable disease (e.g., sniffles, reddened eyes), and/or uncontrolled seizures.

5. If a patient does not show and does not call to cancel, it is considered a "no call, no show." **If there are two "no call, no shows" within a 3-month period then that timeslot is opened to those on the waiting list. The family will be given the option of being placed on our "on-call list" where it is the family's responsibility to call us to schedule weekly therapy appointments.**

I have read and understand Riverwalk Physical Therapy's Privacy Policy and Attendance Policy:

Parent/Guardian Signature: _____ Date: _____

Riverwalk Physical Therapy, L.L.C.
CREDIT CARD AUTHORIZATION

As a courtesy to our patients, we offer the option of paying with credit card on file. If you prefer to make payments this way, instead of paying your cost at each visit, we require your credit card authorization on file. Please complete your information below.

Patient Name: _____
(if different than authorized card holder)

Card Type (please circle one): 

Cardholder Name: _____

Card Number: _____

Expiration Date (mm/yy) ____/____ CVV Security Code ____(not accepted for your security)____

Cardholder Zip Code (from credit card billing address): _____

Signature: _____ Date: _____