All Care Therapies
OF GEORGETOWN

Occupational Therapy•Physical Therapy•Speech Therapy

Patient Information

First Name:_____ Last Name:_____

Parent/Guardians' Names:

_____

Gender:_____ Date of Birth:_____

Address:_____ Apt./PO Box:_____

City:_____ State:_____ Zip:_____

E-mail address:_____

☐ I would like to receive updates and news letter from All Care Therapies to my e-mail address.

How did you hear about us? Please circle one:

Internet Search Doctor Insurance Friend. Who?:_____

Other:_____

Phone Numbers

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone Provider:_____

Preferred Method of Appointment Reminder (circle one): Text Email

Emergency Contact

First Name:_____ Last Name:_____

Phone Number:_____ Relationship:_____

Is this person authorized to take the patient from the clinic?
Circle one: YES NO

Employer

Company Name:_____

Address:_____ Suite/Office #:_____

City:_____ State:_____ Zip:_____

Physician

Primary Care Physician (full name if known):_____

Clinic:_____

Clinic Address (if known):_____

Clinic Phone (if known):_____

Problem

Problem Description:_____

Date of Onset:_____

Medical Information

Current Medications:_____

Known Allergies:_____

Motor Vehicle Accident Injuries

If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in? _____

Primary Insurance

Insurance:_____ ID Number:_____

Group Number:_____ Claim Number:_____

Deductible:_____ Max Annual Benefit:_____

Copay:_____ Coinsurance:_____

Subscriber Information

Subscriber Full Name:_____

Subscriber DOB:_____

Subscriber Relation to Patient:_____

Secondary Insurance

Insurance:_____ ID Number:_____

Group Number:_____ Claim Number:_____

Deductible:_____ Max Annual Benefit:_____

Copay:_____ Coinsurance:_____

Subscriber Information

Subscriber Full Name:_____

Subscriber DOB:_____

Subscriber Relation to Patient:_____

Tertiary Insurance

Insurance:_____ ID Number:_____

Group Number:_____ Claim Number:_____

Deductible:_____ Max Annual Benefit:_____

Copay:_____ Coinsurance:_____

Subscriber Information

Subscriber Full Name:_____

Subscriber DOB:_____

Subscriber Relation to Patient:_____

Patient or Guardian Agreement:

- I authorize release of information requested by my insurance plan for payment.
- I understand that I am responsible for any balance due not covered by my insurance, including co-pays, coinsurances, and deductibles
- I understand that any co-pays required by my insurance company are due at the start of my treatment session.
- I agree to comply with the terms and conditions as outlined in the Patient Registration form.
- I understand that I must notify All Care of any changes in insurance and/or primary care provider immediately.
- In cases of divorced parents, the parent bringing the child to the initial visits will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

Signature of Patient/Guardian:_____

Date:_____

Pediatric History

Full Name of Person Providing Information:_____

Relationship to Patient:_____

Other people in the home:

Name Age Sex Grade (if applicable)

_____

_____

_____

_____

Is there a language other than English spoken in the home ?

Yes____ No____

If yes, which one ?_____

Does the child speak the language ? Yes____ No____

Does the child understand the language ? Yes____ No____

Who speaks the language ? _____

Which language does the child prefer to speak at home: _____

Is there any known history of the following in the immediate or extended family (please circle any)?

Autism/PDD	**Who: _____**	**ADHD**	**Who: _____**
Hearing Loss	**Who: _____**	**Stuttering**	**Who: _____**
Fine Motor Delays	**Who: _____**	**Gross Motor Delays**	**Who: _____**
Learning Disabilities	**Who: _____**	**Speech/ Language Delays**	**Who: _____**

Pregnancy and Birth History

1. Were there any illnesses, injuries, bleeding, or other complications during the mother's pregnancy?

_____

_____

2. Was the mother's pregnancy full term? If not, please give gestational age.

_____

_____

3. Was the labor and delivery normal?

_____

_____

4. What was the mother's method of delivery (vaginal, breech, cesarean)? Were forceps or suction used?

_____

_____

5. Was oxygen or respiratory assistance required after birth?

_____

_____

6. Has your child ever received a medical diagnosis that is related to developmental delays?

_____

_____

7. Has your child received any therapy services in the past? If yes, please provide disciplines received, dates, and location of services provided?

_____

_____

Medical History

Has your child had any of the following ?

- ☐ adenoidectomy
- ☐ allergies
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ ear infections-How many?_____
- ☐ ear tubes
- ☐ encephalitis
- ☐ flu
- ☐ head injury
- ☐ high fevers
- ☐ measles
- ☐ meningitis
- ☐ mumps
- ☐ scarlet fever
- ☐ seizures
- ☐ sinusitis
- ☐ sleeping difficulties
- ☐ thumb/finger sucking habit
- ☐ tonsillectomy
- ☐ tonsillitis
- ☐ vision problems

If checked yes, please provide additional information:

_____
_____
_____
_____

Date of last hearing test: _____ Results: _____

Date of last vision test: _____ Results: _____

Other serious injury/
surgery :_____

Does your child currently have any precautions or restrictions? Yes____ No___

If yes, what are they?

_____

Is your child currently (or recently) under a physician's care ? Yes____ No____

If yes, why? _____

Does your child have any medical equipment he or she currently uses? Including wheelchairs, walkers, orthotics, glasses, etc?

_____

_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones :

_____ Sat Alone

_____ Babbled

_____ Put two words together

_____ Walked

_____ Crawled

_____ Grasped crayon/pencil

_____ Said first words

_____ Spoke in short sentences

_____ Toilet trained

Does your child…

- Choke on food or liquids? Yes____ No____
- Currently put toys/objects in his/her mouth? Yes____ No____
- Brush his/her teeth and or allow brushing? Yes____ No____

Do you have any concerns about your child's behavior ? If so please describe :

_____

_____

_____

School Information

School/Daycare child attends:_____

Facility Address/Location:_____ Grade Level:_____

If Daycare, what times and days_____

Does the child currently receive therapy services through the school district?
Circle One: YES NO

If YES, which services does your child receive through the school district?
Check all that apply:

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech/Language Therapy
- ☐ Other:_____

Does your child have a current IEP or IFSP?

Circle One: YES NO

Please be aware that some insurances require a copy of the child's IEP from the school district before authorizing patient services. It is the parent/guardian's responsibility to obtain the necessary documentation upon request and provide it to All Care Therapies. Failure to provide the requested documentation in a timely manner may result in a disruption of therapy services.

Additional Emergency Contact Information

Please list all adults who are authorized to take your child from the clinic.

Full Name:_____
Relationship:_____
Phone:_____

Full Name:_____
Relationship:_____
Phone:_____

Full Name:_____
Relationship:_____
Phone:_____

Full Name:_____
Relationship:_____
Phone:_____

If an individual who is not on this list is going to bring/pick up your child from therapy, we must receive notice and permission from the parent/guardian of the child **PRIOR** to arrival. For safety reasons, we will **NOT** release a child to an unlisted individual if the parent/guardian has not given notice prior to arrival.

Emergency Medical Treatment Release

I, _____, Father/Mother/Guardian of _____, do hereby give my consent to the Directors of All Care Therapies of Georgetown for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of emergency when the parents or guardians cannot be reached.

_____
Parent/Guardian Signature Date

Annual Physician Visit

It is important that your child be seen by his/her primary care physician at least once a year. Doctors usually will not prescribe therapy treatment or evaluations unless the patient has been seen in the doctor's clinic at least once a year. If you have switched doctors or clinics, you will need to make an appointment with them before they will prescribe therapy treatment or an evaluation.

By signing this document, I certify that I have read and agree to comply with the above policies and have provided accuracy information:

_____
Parent/Guardian Signature Date

Notice of Privacy Practices, Privacy Sheet, Patient Rights and Responsibilities, Attendance Policy, and Clinic Rules
(Laminated Pages in Clinic or attached to Email)

I have read the laminated document provided with this patient intake packet and understand it. I understand that I have the right to ask for a non-laminated copy of the document (or any section(s) of the document) to take home, or have a copy emailed to me.

I have read, understand, and agree to the Notice of Privacy Practices, Privacy Sheet For Client, Patient Rights and Responsibilities, Attendance Policy, and the Clinic Rules. I consent to the use and disclosure of my healthcare information for purposes of treatment, payment, and healthcare options.

_____
Signature Date

If you are signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____
Signature Date

Source of Authority/Relationship:_____

Photo/Video Release

All Care Therapies of Georgetown occasionally takes photos or short videos for treatment and assessment purposes. All Care also has a website (www.allcaretherapygt.com) that is used for promotion and education.

Below is permission or a decline for All Care Therapies of Georgetown to use these photos/videos for educational purposes and legal promotion of the clinic.

Check ONLY ONE Box Below and Fill Out ONLY ONE Section Below

Permission to use Photograph

I grant All Care Therapies of Georgetown, its representatives, and employees to take photographs/video of the patient. I agree that All Care may use such photographs of the patient with or without their name and for any lawful purpose, including, for example, such purposes as education, publicity, illustration, advertising, and Web content.

☐ **I have read and understand the above and give permission for the above use**

Patient Name:_____

Signature of Patient/Legal Guardian:_____

Printed Name:_____

Date:_____

--- --- --- --- --- --- --- ---
--- --- --- --- --- --- --- ---

☐ **Check here if you DO NOT want picture or video taken and used for publicity, but grant permission to use photos or videos for treatment or assessment purposes.**

Patient Name:_____

Signature of Patient/Legal Guardian:_____

Printed Name:_____

Date:_____

--- --- --- --- --- --- --- ---
--- --- --- --- --- --- --- ---

☐ **Check here if you DO NOT want the pictures or video taken of the patient for any purpose.**

Patient Name:_____

Signature of Patient/Legal Guardian:_____

Printed Name:_____

Date:_____

Evaluation Explanation

Thank you for the opportunity to perform your evaluation. It isAll Care's goal and mission to serve the individuals in our area, to help them be more independent, and to improve their quality of life.

After the evaluation is performed, your therapist will score it to determine if therapy intervention is recommended. If therapy is recommended, we will send a request for treatment to the physician to obtain a prescription for treatment. We cannot begin therapy treatment without this prescription. It may take several weeks for your physician to return the prescription for treatment and your insurance provider to authorize therapy treatment. We encourage you to follow up with your physician and insurance provider to ensure communication between parties and timely initiation of therapy treatment. As soon as we receive the prescription for treatment and authorization, we will contact you to begin your therapy treatment. Therapy treatment often is recommended 203 times per week for 30 to 60 minutes each session. The exact amount will be suggested by the therapist. Please be sure that you can commit to this amount of time for your therapy. As explained in our attendance policy, consistent attendance and participation in therapy is vital to patient progress.

It may be possible for your therapist to score the evaluation the same day the evaluation is given to determine if there is a need for therapy intervention. If the evaluation is scored the same day, the therapist ay discuss the results with you if there is time. If therapy is recommended, the therapist may even discuss possible treatment days and times with you. If you have any questions or concerns about the evaluation or treatment scheduling, please do not hesitate to bring them to the attention of your therapist.

If the evaluation cannot be scored the same day, we will contact you about the results and recommendations of the evaluation as soon as the evaluation is scored. A written evaluation report will be completed and a copy will be provided to you for your records.

If at any time you have any questions about how this process works or a concern about therapy, please ask. It is our goal to meet and exceed your expectations for therapy.

Thank you for choosing us,

All Care Therapies of Georgetown