***BACKWAY'S PHYSICAL THERAPY, PLLC*: Pediatric Speech & Language Therapy**

Self-Pay Client Information Form

Welcome to our Practice! ***Sorry these forms are lengthy***, *but they will assist us in fully evaluating your condition and establishing a meaningful treatment plan for you. Please fill them in to the best of your ability.*

PATIENT's NAME______________________________AGE_____BIRTHDATE__________HT_____WT_____SEX____

Parent / Guardian Information

NAME 1 ____ NAME 2 ____

Address ____CITY________________STATE_____ZIP_________

Phones: Home_______________________ Work____________________ Ext_______ Cell ____________________________

Email: ____PARENT'S MARITAL STATUS: S M W D Sep.

CHILD's SOC. SEC. #_______-______-_________ BILLED UNDER SOC. SEC. #_______-______-_________

EMERGENCY CONTACT: Name: _____________________________________Phone#_______________________________

RESPONSIBLE PARTY (Person responsible for paying the bill)

Name____ Relationship to Patient_____________________________________

Address____Zip_____________

HomePhone#_______________________________WorkPhone#__________________________Ext_______________________

DOCTORS' NAMES & PHONE #	
1ST Dr.	2ND Dr.
Phone #	Phone #

- We believe that patients who understand and participate in their health care will achieve the best results.
- We respect your individuality, your rights, and your privacy, and we will give you the best care we possibly can.

Please read the following and sign below.

Self-pay client waiver of insurance use: My dependent is entering into care as a "self-pay" client. By signing this agreement, I am stipulating that, even if I currently have health insurance or other insurance benefits that might cover my care, I am choosing not to use those benefits for Pediatric Speech Therapy received at Backway's Physical Therapy (BPT), and I am directing the BPT staff **not to bill** any insurance on my behalf.

I understand that, if I choose to utilize my insurance benefits at a later date: this cannot be done retroactively; this can only be applied to future dates of service; I must give the treating practitioner at least 48 hours notice, and I must provide the proper medical authorization. Additionally, I understand that changing from a self-pay client to an insurance-based client will necessitate filling in new forms and may necessitate my undergoing a new evaluation procedure to establish medical necessity. **(_____ initials)**

Authorization to leave Messages: In the event that BPT staff cannot speak to me in person regarding the appointments or evaluation results, I give permission to them to contact me and leave a message on *(check all that apply)*: **(_____ initials)**

Answering Machine ___________ Cell Phone ____________ or other location____________________

Payment: I understand that each visit is to be paid for at the time of the visit, unless prior arrangements have been made. I also understand that no one will be denied medical care if they do not have sufficient funds at the time of the visit. However, payment for such visits is expected in full within 10 (ten) days of the visit, ***whether or not I receive an invoice from you***. Payments may be made by cash & check, or by credit card **with an added $5 PayPal fee**. If I cannot pay my account in full, I agree to make a payment plan with your office staff **and adhere to it**. If my account becomes overdue, I will be charged late fees (see page 6). **(_____ initials)**

Cancellations: I understand that I will be charged for an appointment which I miss and do not cancel before 8AM of the day **prior** to my scheduled appointment. **(_____ initials)**

***I have read* the information above, and understand it. I hereby consent to treatment by Backway's Physical Therapy, PLLC.**

Signed____Date______________________________

Printed Name ____

Pediatric Speech and Language Therapy: Initial Questionnaire: Present Problems

*It is important that you inform us of **ALL** medical/health conditions at your first appointment, and immediately inform us of any changes in your child's medical/health condition during your course of treatment.*

***The following forms** will tell us about your child's health conditions, medications, your insurance & contact information. Some of the forms ask for your signatures to give us permissions for billing, treatment, and communication purposes; and for signatures to indicate that you understand how your insurance, our billing, and the Privacy Act (HIPAA) work.*

Please answer these questions to the best of your ability. If something is confusing, leave it blank.

Information About What Brought You Here:

How did you hear about our services? ____

In a few words, please state the overall problem that brought you and your child to Speech Therapy:

____

Now give us more detailed information about your child:

Social Environment

1. Child lives with: both parents mother father siblings (how many ___) other ______________
2. Child's primary language:____
3. Any other languages spoken in the home ___________________________________
4. Name of school and current grade: _______________________________________
5. Any problems or concerns at school? _____________________________________

Speech/Language Concerns

1. Do you feel your child has difficulty communicating? Yes ☐ No ☐
   If yes, please describe in detail: ____
2. When did the communication difficulties begin? _______________________________
3. Has the child had a hearing test? Yes☐ No☐
   If yes, when was the test and what were the findings? ___________________________
   ____
4. Has the child ever had a speech/language evaluation? Yes ☐ No☐
   If yes, when and where was the evaluation? _________________________________
   What were the findings? ____
   ____
5. Has the child ever received speech/language therapy? Yes ☐ No☐
   If yes, when and how long was the course of treatment? _________________________
   ____
6. Are there any other concerns about the child's development? Yes ☐ No☐
   If yes, please describe: ____
   ____
7. Does the child exhibit any physical or emotional difficulties? Yes ☐ No☐
   If yes, please describe: ____
   ____

Patient name: _______________________ Date: __________

8. Does the child become agitated or frustrated because of lack of communication skills? Yes ☐ No ☐
   Please describe any other behavioral issues: ____

Birth History

1. Was the pregnancy free of complications? Yes ☐ No☐
   If no, please describe: ____
   ____

2. Was the child born full-term? Yes ☐ No☐
   If no, how many weeks? ____
   Please describe any issues or concerns: ____
   ____

3. Was the child discharged with the mother? Yes ☐ No☐
   If not, please describe why, and the length of hospital stay: _________________________________
   ____

4. What was the mother's age when the child was born? _______________________________________

Medical History

1. Has the child had any of the following?

☐ Adenoidectomy	☐Ear infections	☐ Allergies	☐Seizures
☐Tonsillectomy	☐Ear tubes	☐Asthma	☐Head injury
	☐Thumb sucking habit	☐Sleeping difficulties/Snoring	☐ Complications at birth

2. Please describe in detail any other issues you feel are pertinent to today's visit.
   ____
   ____

3. Please describe any other serious injury, surgery, hospitalization, or ongoing medical conditions:
   ____
   ____
   ____

4. Please list any known allergies: ____

5. Please list any other physicians or therapists involved in your child's care:__________________________________
   ____
   ____

Developmental History

1. Please give the approximate age at which your child achieved the following milestones:
   Sat Alone _________ Walked _________
   Babbled _________ Said first words _________
   Put two words together __________ Spoke in short sentences _________

2. Does the child:
   Understand you? Yes ☐ No☐
   Follow simple directions? Yes ☐ No☐

Patient name: _________________________________ Date: ____________

Make wants/needs known using words? Yes ☐ No☐
Respond appropriately to yes/no questions? Yes ☐ No☐
Communicate with gestures? Yes ☐ No☐
Become frustrated easily? Yes ☐ No☐

Swallowing History

1. Please describe the nature of the swallowing problem(s):____

____

2. When did the problem(s) begin:____

3. Has the problem improved at all since it began? Yes☐ No☐
   If yes, please explain: ____

   ____

4. Does the problem(s) only occur with certain foods or liquids? Yes☐ No☐
   If yes, please list which foods or liquids:____

   ____

5. Does the problem(s) present only at certain times of day? Yes☐ No☐
   If yes, please explain: ____

   ____

6. Has the patient had a video swallowing study? Yes☐ No☐
   If yes: when and where? ____
   What were the findings? ____

   ____

Thank you *for providing this information for us. Please, let us know of any health changes.*

Magnitude of Symptoms:

Please indicate on the scale below the magnitude of your child's problem(s):

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Intense Severe Intolerable

Goals:

What results do you want from Pediatric Speech Therapy? ____

____

____

Patient name: ________________________________ Date: ___________

Backway's Physical Therapy: Intake Form *Pediatric Speech Therapy:* Patient Medication List

Please look at the labels on your child's medications & supplements; then list them below. This includes all prescription, over-the-counter, herbals, vitamins, minerals and dietary/nutritional supplements your child takes routinely, and/or on an as-needed basis.

Medication or Supplement Name	**Dosage**	**How many times/day?**	**Is this taken by mouth or other route?**	**What condition is this for?**	**"May cause dizziness" label on it?**	**Does this med make you dizzy?**
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Therapist notes: Is form complete? ❑ Yes, ❑ No. If no, reason not completed: ❑ Pt refused ❑ Emergency ❑ Pt cog unable **(initials: ________)**

Patient Name: ______________________________ **Date:** ________________

Backway's Physical Therapy, PLLC **SELF PAY – <u>Authorizations</u> <u>&</u> <u>Office/Financial</u> <u>Policy</u> <u>Form</u>**

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. ___________ (please initial)

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***Optional*: Consent for Use of Information for Presentations, Research and/or Publications (optional)**
I grant permission, now and in future, to Backway's Physical Therapy, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education, research and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. My signing of this authorization is **not** a condition to receive treatment by Backway's Physical Therapy personnel.
(Optional) Patient's/Guardian's Signature ______________________________ Date ___________

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All Authorizations below are Mandatory:
Receipt of HIPAA Patient Privacy Notice: My signature below indicates that I have received the HIPAA Patient Privacy Notice. I consent to your use and disclosure of protected health information about my dependent for treatment, payment, health care operations, and/or as required by law and by HIPAA. **(_____ initials)**

Consent for Treatment: I hereby authorize the professional staff of Backway's Physical Therapy to evaluate and treat my dependent. During the course of evaluation and treatment, I authorize the licensed personnel at Backway's Physical Therapy to use any and all techniques they have been trained to use, which they believe will benefit my child, in order to help my child recover. I have the right to refuse a specific technique or form of treatment, if I so choose.**(_____ initials)**

Consent for Mutual Exchange of Information: I authorize the mutual exchange of information regarding my dependent, between the Backway's Physical Therapy staff members, and all professional practitioners involved in the healthcare of my dependent, at any time (i.e. doctor, chiropractor, counselor, etc). Your office may also talk with the non-practitioner persons listed below about my child's health information: **(_____ initials)**

Guardian 1	Name:	phone#:
Guardian 2	Name:	phone#:
Teacher	Name:	phone#:
Other	Name:	phone#:
Other	Name:	phone#:

Missed appointments: No-Shows; Frequent Cancelations & Cancelations Without Adequate Notice:
If I need to cancel an appointment, I must let you know before 8AM of the day prior to my dependent's scheduled appointment to avoid a cancelation fee. *If I cancel late*, or if he/she does not attend the appointment, **I will be charged** a missed-appointment fee which may be equal to the full treatment session price. **(_____ initials)**

Overdue Accounts: All overdue accounts are subject to late fees (table below). Self-pay accounts start accruing fees 30 days after service is rendered. Liens start accruing fees 90 days after discharge from therapy.

Past Due Balance	$20 - $100	$101 to $750	$751 to $3000	Greater than $3000
Monthly Late Fee	$15	$25	$50	$75

Returned check fee: A fee of $25 is charged on all returned checks.
Collections: Returned checks and failure to pay account balances overdue for 90 days may result in our referring your account to an outside collection service. **(_____ initials)**

We may refuse service to a client under certain circumstances. Refusal is usually due to, but is not limited to: non-payment of past accounts; repeated missed/canceled appointments; inappropriate behavior; and the therapists' opinion that our services won't benefit a client or aren't medically necessary. **(_____ initials)**

I have read and fully understand the above statements and agree that they apply to <u>all</u> treatments that my child receives* at Backway's Physical Therapy. I agree to pay for all services rendered at the time of service, *unless previous arrangements have been made.

➔Guardian's Signature ______________________________________ Date ____________

Patient's Printed Name: ______________________________________