Play. Learn. Grow.

Oklahoma Pediatric Therapy Center

Patient Identification

Last Name | First Name | Middle Name | Gender

Date of Birth | Age Years - Months | Social Security Number

Home Address | City | State | Zip Code

Email Address | Primary Contact Phone Number

Child's Pediatrician | Pediatrician Phone Number | Name of Pediatric Office/ | City, State

Would you like to receive text messages regarding your child's appointment? YES NO

Text Phone Number

Patient Family Information

Parent/Guardian Name | Relationship to Child | Contact Phone Number

Parent/Guardian Name | Relationship to Child | Contact Phone Number

Child lives with (check one): ☐ Birth Parents ☐ Foster Parents ☐ Adoptive Parents ☐ One Parent ☐ Other

Other Children in the Family: Name | Age | Gender

Is there a language other than English spoken in the home? YES NO If yes, which one? _____

What is the Primary Language spoken in the home? _____

Insurance Information

Primary Insurance Carrier | Policy Holder's Name | Policy Holder's DOB | Policy # | Group #

Secondary Insurance Provider | Policy Holder's Name | Policy Holder's DOB | Policy # | Group #

Patient Name _____

Why are we seeing you today?

Reason for Referral (Check all boxes that apply.) Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐

What are your Pediatrician's Concerns?: _____

What are YOUR main concerns regarding your child's development?_____

_____

What are some goals you have for your child? _____

Medical Case History

Please help our therapist get ready to evaluate your child. We appreciate all the information you can give us. *We're here to help*!

1.Prenatal and Birth History:

Child was born: Full Term _____ Premature _____ How many weeks premature? _____

Delivery: Vaginal _____ Forceps _____ Vacuum _____ C-section _____

Birth Weight: _____

Did you have any complications? _____

Was your child placed in the Intensive Care Unit? _____ If so, How long? _____

Please describe any other prenatal medical problems or complications at birth: _____

2. Medical History:

Does your child have any allergies? YES NO If yes, what: _____

Are they taking any medications? YES NO If yes, what: _____

Please list any hospital stays or surgeries including approximate ages: _____

Current or Ongoing Health Concerns: _____

Special equipment your child uses: Splints _____ Braces_____ Adaptive Utensils_____ Wheel Chair_____

History of Ear Infections: YES NO Date of Last Hearing Screening: _____

Date of Last Vision Screening: _____

Please check all that apply to your child:

___ Hearing Aids ___Hearing Difficulty ___Ear Tubes ___Chronic Ear Infections ____Surgeries

___Vision Difficulty ___Vision Testing ___Glasses ___G-Tube ___ C-Line _____Reflux

___ Seizures ___Asthma ___Allergies ___History of Broken Bones: _____

___ Neurological Condition ___Dietary Restrictions ___Psychological Disorder ____Pain ____Diabetes

Explanations of Any Medical Conditions:

_____

3. Developmental Milestones: (mark approximate month)

Rolled Over _____ Babbled _____ Said First Word _____ Sat Alone _____ Crawled _____

Drank from a Cup _____ Walked Alone _____ Pulled to Stand _____ Used a Spoon _____

Responded to Name _____ Points and Names Objects _____ Toilet Trained _____ Dressed Self: _____

Current Physical Limitations: _____

What is your child's hand dominance? RIGHT LEFT BOTH

4. School History/Previous Therapy

Is your child currently receiving therapy in a school? YES NO Is your child on an IEP? YES NO

Name of school currently attending and grade: _____

Special services received in school (include teacher/therapist if known):

OT_____ PT _____ Speech _____ Special Education _____ Behavior Intervention _____

Does your child's teacher have concerns with your child's development in any of the following areas?

Motor Skills _____ Social Abilities _____ Self-Help Skills _____ Learning Abilities _____ Speech _____

Has your child ever repeated a grade? _____ If yes, when: _____

School History including Pre-school, SoonerStart, and other Early Intervention: _____

Extracurricular Activities: _____

Has your child ever had therapy outside of school? YES NO
Has your child ever received an evaluation by a SLP, PT, or OT before? YES NO If yes, when: _____

Previous Therapy _____ _____
Name of Clinic/Therapist Dates of Therapy (from-to)

5. Behavior

Please check any of the following that apply to your child:

____ Cries often	____ Grinds teeth	____ Sensitive to sounds
____ Dislikes hair brushing	____ Seems to be "on the go"	____ Avoids touch from others
____ Clumsy	____ Poor attention span	____ Dislikes tooth brushing
____ Weak Muscles	____ Trouble transitioning	____ Anxious
____ Rocks self	____ Picky eater	____Sensitive to light
____ Craves jumping/crash play	____ Trouble attending to task	____ Mouths objects
____ Trouble with directions	____ Dislikes playground	____Has trouble playing with others
____Stubborn	____Willing to try new activities	____ Poor eye contact
____ Self-Abusive behavior	____ Attentive	____ Cooperative
____ Separation difficulties	____ Restless	____ Withdrawn
____ Inappropriate behavior	____ Impulsive/easily frustrated	____ Prefers playing alone

Does your child have sleeping difficulties? YES NO Explain: _____

____ Snoring _____ Difficulty falling asleep _____Difficulty staying asleep _____Restless _____Apnea

What do you see as your child's most difficult problem at home or at school? _____

_____

Do you feel like your child is frustrated or aware of any speech/ and or motor difficulties he or she may have? _____

_____

Would you like for us to know anything else about your child? _____

_____

Likes? _____ Dislikes?_____

How does your child communicate his/her wants or needs? ____ Cries _____Points ____ Uses Short Sentences

____Uses Long Sentences _____Uses One Word at a Time ____Makes Sounds

6. Feeding History

Early Feeding: (Circle all that apply) Bottle Breast Both Until what age: _____

Any difficulties with early feeding: _____

Please check any problems that your child might be having with feeding/swallowing:

___Gagging ___Choking ___Reflux/GERD ___Excessive Drooling

___Food Stuffing ___Pocketing/Holding ___Puree foods ___Solid Foods

___Cup Drinking ___Straw Drinking ___Self-Feeding ___Picky Eater

Please describe checked items: _____

Any nutritional concerns? Is your child eating a good variety of foods? _____

Food preferences that you've noticed? (Likes/Dislikes, Tastes, Textures) _____

Additional Comments: _____

7. Speech

Tell us about babbling/cooing behavior? _____

Does it seem normal? YES NO Would you say it's a LITTLE or A LOT?

First words, was it before 18 months _____ or after 18 months _____?

When did your child begin to combine words into simple phrases or sentences? _____

Please give us some examples of common sentences your child says: _____

_____

Is your child easy to understand by family members or are you constantly acting as the interpreter? _____

What percentage of your child's speech do you understand? _____

Does your child...

____ Repeat sounds, words or phrases over and over ____Understand what you are saying

____ Retrieve/point to common objects upon request (ball, cup, shoe) ____Follow simple directions ("Shut the door.")

____ Respond correctly to yes/no questions ____Use body language to communicate

Authorization and Consent to Treat

I hereby authorize and provide permission for OPTC to receive information from and/or speak to my child's doctor, teachers, and any other professionals currently working with my child in regards to pertinent information, treatment goals, and progress being made. Agree Initial _____

HIPPA Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices of the practice/clinic. I understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restrictions(s). I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed. Agree Initial _____

Insurance/ Patient Payment Requirements

I authorize for all insurance payments to be made directly to OPTC for therapy services rendered. **I acknowledge that I am financially responsible for all charges not covered by my insurance provider**. I further acknowledge that my insurance company may limit therapy benefits, and I am responsible for understanding those benefits at all times. As a courtesy, OPTC tries to check coverage. However, the patient is responsible to check these benefits and coverage and fully understand benefits allowed. I will be responsible for all charges accrued if my insurance denies service. I understand that my copay will be paid every time I see a therapist. I also understand that my bill cannot exceed $350 at any time or my child's name will return to the waiting list until outstanding bill is paid and a new time slot opens up. The patient will be responsible to pay a $25 fee for any returned checks. Agree Initial _____

Cancellation Policy

Here at OPTC, we strive to provide the best **one-on-one** care possible. The appointments you make will be reserved and planned specifically for your child. To receive the maximum benefit of treatment, it is important that you attend each of your scheduled appointments and that you arrive on time for your appointments. Providing one-on-one care to each patient requires that we do not overbook or double book our appointments. Unfortunately missed appointments result in open slots in our therapists' schedules and are a lost opportunity to help other patients. While we understand emergency situations, and times when you will have to cancel- our facility requires a **$25 fee for treatments that are not cancelled within 24 hours of the scheduled appointment time**. This fee is your responsibility and must be paid prior to your next scheduled treatment. Agree Initial _____

Attendance Policy

We are thrilled you've selected our services to meet your therapy needs. OPTC strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. We offer excellent therapy that is tailored to fit each patient's specific needs. Cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We must ask for your full cooperation with the following policy:

- Consistent attendance during the therapy process is the first step in offering exceptional care and treatment outcomes.
- Consistent attendance during therapy is critical for a successful therapy program and your responsibility.
- Consistent attendance will ensure: Optimal conditions for the therapy process and efficient use of the therapist's time and energies.

We expect 90% attendance in our therapy programs for a 30-day period. In the event that you do not call to cancel your appointment or inform our clinic that you will not be attending, it will be recorded as a No Show. You will receive a letter after two No Show appointments as a warning of dismissal. Three No Show appointments will result in dismissal from your current therapy schedule and you will be placed on the waiting list for services

Chronic cancellations are also considered problematic. Patients with attendance below 80% in a 30-day period will also be dismissed from current therapy and placed at the bottom of the waiting list. A letter will be sent to your primary care physician (PCP) explaining the reason for

discharge from our services. In order to resume services, you will need to obtain a new referral from your PCP and reschedule. We do understand there are special circumstances that can occur and we will review those carefully before making our final decision.

Agree Initial _____

If at all possible, we would like to reschedule the appointment rather than have you cancel. Thank you for your cooperation regarding our attendance policy.

I have read and understand the above attendance policy for Behavioral, Speech, Occupational and Physical Therapy Services. I have also been provided a copy of this attendance policy.

_____ _____

Parent's Signature Date

Patient Name_____

Oklahoma Pediatric Therapy Center

Release of Photo

We would like your permission to use any pictures, taken at our facility, on our website or our social media pages. Pictures will be posted to our Facebook and Instagram pages. We will never reference your child by name or provide any specific information regarding your child.

Please take a moment to let us know your preferences regarding our use of photos of your children. Please circle Yes or No:

- **YES** I grant permission to use photos of my child on OPTC pages.

  OR

- **YES** I grant permission to use my child's photo without showing his or her face.

- **NO** Please do NOT take or use any photos of my child.

Child's Name:_____

Parent/Guardian Signature:_____

Relationship to Child:_____

Date:_____

Oklahoma Pediatric Therapy Center

Patient Name: _____

E-mail and Text Messaging Program Consent Form

We are happy to provide our patients with the option to participate in our online patient communication system. This includes the ability to:

- Receive text message appointment reminders
- Receive e-mailed notices, information, etc.

You may choose to discontinue your participation in our online communication system at any time simply by replying "unsubscribe" to the e-mail or by replying "STOP" to a text message sent from us. Standard text messaging rates may apply.

Please provide the following contact information:

Home Phone: _____

Cell Phone: _____ (if you wish to receive text msg. reminders)

E-mail: _____

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment, as well as, overall service and satisfaction. We may disclose **Patient Health Information (PHI)** to third parties that perform services for this practice in the administration of your benefits in accordance with **HIPPA**. These parties are required by law to sign a contract agreeing to protect the confidentiality of your **PHI**. Your **PHI** may be disclosed to an affiliate that performs services for this practice in the administration of your benefits. Our affiliates do not sell, share, or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without your permission, and do not send spam.

Please sign below to indicate that you agree to allow us to use this information in providing your services.

_____

Signature Date

CAUTION. THIS IS A RELEASE. READ BEFORE SIGNING.

RELEASE OF LIABILITY, WAIVER, INDEMNITY AND ASSUMPTION OF RISK AGREEMENT

I, the undersigned participant and/or the parent or legal guardian of a minor participant ("Minor Participant") named on this form, acknowledge, agree and understand that in contracting to receive care provided by Complete Rehab, LLC/dba Oklahoma Pediatric Therapy Center, its employees, agents, contractors and members (collectively "Oklahoma Pediatric Therapy Center") and in agreeing to use the equipment and facilities provided by and located at 1824 Commons Circle, Yukon, OK 73099, or any substitute facilities (collectively, the "Facility" or "Facilities"), I fully understand, acknowledge and agree to the terms stated in this Release of Liability, Waiver, Indemnity and Assumption of Risk Agreement ("Agreement").

In exchange for Oklahoma Pediatric Therapy Center, permitting the Participant, , to use the Facilities of Oklahoma Pediatric Therapy Center, I hereby agree to release, indemnify and discharge Oklahoma Pediatric Therapy Center, all agents, members, owners, shareholders, directors, employees, volunteers, manufacturers, other participants, affiliates, subsidiaries and all other related entities, successors and assigns, (cumulatively referred to as "Released Persons") on behalf of myself, the Participant or Minor Participant, my spouse, my domestic partner, my children, my family members, heirs, assignees, assignors, representatives, trustees, executors, and anyone acting on my behalf or on behalf of my estate. I further agree, as follows:

1) I agree to review and diligently abide by all posted rules concerning use of the Facilities.

2) I will personally supervise my Minor Participant(s) (if applicable) at all times while using the Facilities.

3) This Agreement shall apply to any activities in which I (or my Minor Participant) will engage as part of any treatment provided while at the business location of Oklahoma Pediatric Therapy Center and/or any activities I (or my Minor Participant) engage in while at the business location of Oklahoma Pediatric Therapy Center that are not related to my treatment. This Agreement shall apply to any activities while playing, participating in treatment, or while at the Facilities in a non-playing capacity as an observer during play or treatment by others.

4) I acknowledge and agree that my participation and use of the Facilities (including its equipment) at the business location of Oklahoma Pediatric Therapy Center entails known and unknown risks that may result in serious physical injury, emotional injury, death, or damages to me, my property or to third persons and third persons' property. I fully understand that there are known and unknown risks included with the activities that I voluntarily agree to participate in that cannot be reasonably eliminated. Some of the risks resulting from my voluntary participation include, but are in no way limited to, scrapes, cuts, bruises, serious injury to one's person, sprains, breaks, muscle injuries, harm caused by existing medical conditions, acts and omissions of other persons and other participants. I fully understand and accept these risks as well as any risks that are unknown to me upon the signing of this Agreement that may result in medical assistance, medical expenses, and medical emergencies.

5) I certify and promise that I have adequate insurance to cover any injury or damage that may be caused by my participation and suffered upon my person, my property or other persons. I agree to pay the entire costs associated with injury to or damage to myself, my property or other persons and their respective property. I agree to hold harmless and indemnify the Released Persons for all costs associated with injury to or damage to myself, my property or other persons and their respective property.

6) Risks can be minimized with careful parental supervision. Intending to be legally bound, I hereby, for myself, my heirs, assigns, executors or administrators, waive all claims for damages against Oklahoma Pediatric Therapy Center for any and all injuries and/or losses that I, assisting guardians, assisting caregivers and/or my Minor Participant may sustain while using the Facilities for treatment or other purposes. I fully acknowledge and understand that the employees of the Released Persons may be negligent in supervising and maintaining the Facilities owned and operated by the Released Persons. I fully understand and accept the risk associated with employees' negligence that may or may not occur in the monitoring, supervising, and maintenance of the Facilities owned and operated by the Released Persons.

7) If I, or a representative on my behalf, file a claim or any legal action against the Released Persons, I agree that the substantive law and procedural law of the State of Oklahoma shall apply in that action regardless of the conflict that may result from the laws of any other state. I agree that if any portion of this Agreement is found to be unenforceable or void for any reason, the remaining portions shall remain in full force and effect.

8) I agree that if the Participant is a minor, as determined by Oklahoma state law, this Release of Liability and Assumption of Risk Agreement is made on behalf of that Minor Participant and the releases, waivers and promises contained herein are binding on the Minor Participant and that I have full authority as a parent or legal guardian to bind the Minor Participant to this Agreement without limitation.

9) I voluntarily release, discharge and agree to defend, indemnify and hold harmless the Released Persons from any and all claims, demands, causes of action, lawsuits or any other legal proceeding which are in any way connected to or related to my participation and the participation of Minor Participants in the use of the Facilities owned and operated by the Released Persons, including all claims that allege negligent acts and omissions of the Released Persons and all claims which allege negligent acts or omissions of other persons.

10) I agree that if the Participant is a minor that I shall defend, indemnify and hold harmless the Released Persons from any and all claims, lawsuits, or any other legal actions relating to property or personal injury brought by or on behalf of the minor and are in any way related to or connected to the minor's participation.

11) Nothing in this Agreement shall constitute an admission of liability by any party. This Agreement and actions taken hereunder may not be interpreted or construed as an admission by any party of any liability or wrongdoing whatsoever or the validity or liability of any legal theory or cause of action.

12) This Agreement shall be binding on the Participant and anyone acting on my behalf or behalf of my estate in perpetuity.

13) *I agree that if a dispute or claim of any kind shall be pursued against a Released Person, same shall be pursued in the State of Oklahoma. I agree that any dispute that I may have with the Released Persons or any other persons related to my participation and use of the Facilities owned and operated by the Released Persons shall be pursued through Arbitration as approved by the American Arbitration Association. Any such arbitration shall be conducted in Oklahoma City, Oklahoma. I agree to pursue any and all claims that may arise against the Released Persons through the Arbitration Services approved by the American Arbitration Association and voluntarily agree to be bound by the decisions and recommendations made by the Arbitrator. I understand that, for such claims, I am voluntarily waiving my rights to pursue the Released Persons in local, state and federal courts in favor of Arbitration.*

By signing this Agreement, I acknowledge that if anyone is injured or property damaged during my participation or use of the Facilities owned or operated by the Released Parties, that I have voluntarily waived my rights, or the minor Participant's rights to file or otherwise maintain a lawsuit against any Released Persons. I have had sufficient opportunity to read this entire Agreement. I have read this entire Agreement. I understand this entire Agreement and voluntarily agree to be bound by its terms without limitation.

CAUTION - THIS IS A RELEASE - READ BEFORE SIGNING

Name of Participant _____

Must be completed by parent or legal guardian of Minor Participant

Name of Parent or Legal Guardian _____ Relation_____

Must be signed by Participant, if over the age of 18; or parent or legal guardian of Minor Participant.

SIGNATURE _____ Date _____