ATLAS
PHYSICAL THERAPY
A H2 Health Company

PEDIATRIC THERAPY QUESTIONNAIRE

Basic Information

Child's Name: _____Date of Birth: _____ Gender: _____

Parent Names: _____

Home Phone: _____ Cell Phone: _____ Cell Phone: _____

Email Address(es): _____

Please indicate (*) preferred method of communication above (home phone, cell phone, email)

Referring Physician: _____

Physician Phone Number and Address: _____

Reason for referral/concerns: _____

_____

Primary Physician (if different from above): _____

Physician Number and Address: _____

School: _____ Grade: _____ Teacher: _____

Days/Times Child Attends: _____

Does your child receive therapy services at school? If yes, list services. _____

_____

Reason for Referral:

What are your primary concerns? _____

What specific skills would you like your child to improve with therapy? _____

_____

Home environment

Are any languages other than English spoken in the home (please list)? _____

If yes, who speaks the language? _____

Which language(s) does your child speak/understand? _____

Developmental and Medical History:

Your child was born at _____ weeks. Birth Weight_____ Vaginal or C-Section (please circle)

Were there any complications during pregnancy? Yes No

If yes, please describe (any infections or illnesses, stress, complications, medications)

_____

Were there any complications during labor and delivery? Yes No

If yes, please describe (induction, breach, forceps, etc.) _____

Were there any complications following birth? Yes No

If yes, please describe (NICU stay, need for oxygen and/or fetal monitor, congenital abnormalities, need for surgery, difficulty with feeding, jaundice, colic, etc.) _____

_____

Has your child had any of the following:

☐ Adenoidectomy	☐ Encephalitis	☐ Surgery (specify below)
☐ Asthma	☐ GI issues	☐ Strep throat
☐ Breathing difficulties	☐ Head injury	☐ Tonsillectomy
☐ Breaths from mouth only	☐ High fevers	☐ Tonsillitis
☐ Ear infections	☐ Meningitis	☐ Vision Problems
How many/often? _____	☐ Seizures	
☐ Ear tubes	☐ Sleeping difficulties	

Please list any other significant illnesses, surgeries, hospitalizations, etc. _____

_____

_____

Please list any specialists your child has seen, along with date and reason for visit. _____

_____

Has your child had a hearing evaluation? _____ _____

Has your child had a vision screening? _____

Does your child wear glasses? _____

Please list any medications your child takes. _____

_____

I have provided Atlas Physical Therapy with a complete list of current medications including ALL prescriptions, over-the-counter, herbs, supplements and vitamins. _____ **(initial)**

Please list any allergies (food, medication, etc.) your child has. _____

_____

Please list any diagnoses your child may have received. _____

_____

Please list any therapy services your child has received or is receiving (include dates and current schedule)

_____

_____

Are there any precautions we should know about your child that are not described above? _____

_____

To the best of your knowledge, at what age did your child:

Roll over _____	Sit Independently _____	Crawl _____
Stand Alone _____	Walk _____	Go Up/Down Stairs _____
Finger Feed _____	Transition to solid foods _____	Transition Bottle to Cup _____
Feed Self with Utensils _____	Toilet Train _____	Sleep through the night _____
Say First Word _____	Put Two Words Together _____	Babble_____

Please list any concerns regarding mobility/walking (feet turn inward, frequently tripping/falling, toe walking, etc)

_____

_____

Daily Routine:

What time does your child go to bed on weeknights? _____ Weekends? _____

Does child have difficulty falling asleep? _____

Does child wake during the night? _____ If so, how often? _____

For what reason? _____

Does child seem well rested after waking? _____

What are your child's favorites toys/activities/interests? _____

_____

What are your child's fears/dislikes? _____

_____

What things work to motivate your child? _____

_____

Dressing:

Can your child fully undress him/herself? Yes No
If no, what items does your child need help to take off? _____

Can your child fully dress him/herself? Yes No
If no, what items does your child need help to put on? _____

Can your child:
Button? _____
Snap snaps? _____
Zip jacket? _____
Tie shoes? _____

Does your child prefer certain fabrics only (if yes, please explain)? _____

Bathing: Are there any concerns or behaviors noted with bath time?

_____

_____

Feeding:

Please list your child's food preferences: _____

Please list your child's food dislikes: _____

Are there any concerns with feeding? (picky eater, unable to sit through meals, difficulty with utensils, etc.)

_____

_____

Sensory:

Does your child have difficulty tolerating any of the following? (list any concerns)

Brushing Teeth: _____

Brushing Hair: _____

Hair Cuts: _____

Nail Cutting: _____

Washing Hands: _____

Toileting: _____

Does your child: Avoid eye contact? Yes No Chew on non-food items? Yes No

Social Skills and Behaviors:

Please describe how your child approaches and responds to new environments and new people. _____

_____

Describe how your child tolerates schedule/routine changes_____

Does your child have frequent interaction with same-age peers or other children (siblings, classmates, etc.)?

_____

Does your child interact well with other children? _____

Does your child have difficulty being in large crowds? _____

When given a choice, does your child prefer to play alone or with others? _____

Does your child engage in eye contact during communication? _____

Describe your child's safety awareness. _____

Describe your child's attention span. _____

Is your child able to follow: Single step directions? Yes No 2-3 step directions? Yes No

Does your child demonstrate self-stimulating behaviors? Describe. _____

_____

Is there any other information or other concerns you would like us to know about your child? _____

_____

_____

IF YOUR CHILD IS HERE FOR A SPEECH EVALUATION OR YOU HAVE SPEECH CONCERNS, PLEASE COMPLETE THE NEXT SECTION. IF NOT, SKIP TO PAGE 7

Speech/Language & Feeding

When did you first notice the problem: _____

How severe is the problem? Mild Moderate Severe Very Severe

Is your child aware of, or frustrated by, the speech/language difficulties? Yes No

If yes, please describe: _____

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

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

How does your child currently communicate his/her wants/needs to you? _____

Have any siblings or immediate family members had speech/language difficulties? Yes No

If yes, please describe: _____

Did/does your child have difficulty: Sucking ____ Chewing ____ Swallowing ____ Transitioning to solids _____

Do you have concerns about your child's hearing currently? _____

Does your child appear to understand what is said? _____

Atlas Physical Therapy

Patient Information Form

Last Name _____ First Name _____MI ____ SSN _____

Address: _____

City _____State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Gender _____ Marital Status_____ Email _____

Emergency Contact

Last Name _____ First Name _____

Phone: _____ Relationship _____

Employer

Name _____ Phone _____

Address: _____

City _____ State _____Zip _____

Problem

Problem Description _____ Date of Injury _____

Referred by _____ Last Physician Visit _____

Motor Vehicle Accident? _____State of Accident? _____

Notes: _____

Primary Insurance

Insurance _____ ID# _____ Group # _____

Copay _____ Coinsurance _____Deductible _____

Subscriber Name _____ Relationship _____ Subscriber DOB _____

Secondary Insurance

Insurance _____ ID# _____ Group # _____

Copay _____ Coinsurance _____Deductible _____

Subscriber Name _____ Relationship _____ Subscriber DOB _____

I give consent to Atlas to provide treatment.
I authorize release of information requested by my insurance for payment.
I assign benefits from the designated payer to Atlas.
I understand that I am financially responsible for any balance due.
I have received a copy of the Notice of Privacy Practices, Financial and Attendance Policy

Signature _____ Date _____

Communication

☐ I give permission to communicate with me via cell: _____

In order for your appointment reminders to be sent, the cell phone provider is required.

My cell phone <u>provider</u> (*Example: AT&T, Verizon, MetroPCS, etc).***is:** _____

☐ I give permission to communicate with me via email: _____

Guarantor Information

Guardian Name: _____ DOB: _____

Relationship to Patient_____ Phone Number: _____

Permission to Speak/Leave Detailed Messages

Please list the patient whose information is to be disclosed:

Patient Name: _____ DOB: _____

I give permission for you to discuss or leave a phone message with information regarding my medical treatment, appointment schedule and financial information with the person(s) listed below

Name: _____

Relationship to Patient_____ Phone Number: _____

Name: _____

Relationship to Patient_____ Phone Number: _____

Patient/Guardian Signature: _____ Date: _____

How did you hear about Atlas? (*Please circle)* Patient Physician Facebook

Website/E-News Letter Staff Member Friend/Family Community Event

Photo & Promotional Release

I hereby consent to be interviewed, recorded, photographed, videotaped or filmed by representatives of Atlas Physical Therapy LLC for purposes of publication, display or broadcast (print, web, digital display and all other forms of media). I agree that such interviews, recordings, articles, quotes, photographs, films, audio or video and/or and reproductions of same in any form, are the property of Atlas Physical Therapy LLC, and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

I hereby release Atlas Physical Therapy LLC, its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed, recorded, photographed, videotaped or filmed.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Patient Name (print): _____

Patient/Guardian Signature: _____ Date: _____

**Parent or Legal Guardian name and signature required for individuals under the age of 18.*

ATTENDANCE POLICY

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. **We require that you cancel any appointment that you cannot make with no less than 24 hours' notice.**
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. While we understand that illness can strike at any time, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will arrive on time and ready to begin at your scheduled treatment time.
6. **Life happens and sometimes we all run late. We get it. If you are running late, we need you to call us immediately so we can be prepared for your late arrival.**
7. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times or may be discharged.
8. **Please note, you will be charged a $25 fee for any no-shows and ALL cancellations that occur with less than 24 hours' notice. This amount is your responsibility as insurance will not cover this fee.** To avoid the $25 fee, you simply need to call the office and provide at least 24 hours' notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice so please call during business hours. *Advanced notification allows us to help another patient by offering them your appointment slot.*
9. You may be discharged from services if you do not show up for your appointment or cancel for 2 consecutive appointments or if attendance falls below 75%.
10. Long-term patients may request a temporary hold in therapy for appropriate circumstances. A standing appointment time will not be reserved if the hold is greater than 2 weeks.
11. Pediatric patients will not be left unaccompanied for their safety and must be supervised by parent/guardian until the therapy sessions begins and promptly picked up at the end of the visit. If a pediatric patient is not promptly picked up at the end of the therapy session, therapy may be discontinued.

FINANCIAL POLICY

Atlas Physical Therapy is committed to giving you EXCEPTIONAL SERVICE and TREATMENT. Part of our commitment is to make sure you understand your health insurance coverage and make your services more affordable with payment options. **We will verify your insurance eligibility and benefits**. Based upon the information you provide to us, our billing team will contact the payer to determine what benefits are available. It is your responsibility to provide to us accurate and current information. Failure to notify us of any changes could result in denial by the insurance company in which case payment becomes your responsibility.

We will explain your benefits We will provide you with an Insurance Benefit Information Statement outlining your plan benefits the carrier has relayed to us. We do recommend however that you verify the information your carrier has relayed to us. We will send the claim to the insurance company as a courtesy; however you or the guarantor is responsible for services not covered.

We will work with you to pay your portion of services.

To make therapy services more affordable, we will follow these guidelines

- If you have a co-pay, we will collect it at the beginning of each visit.
- If you have a co-insurance, we will collect an estimate of your percentage at the beginning of each visit.
- If you have a deductible, we will collect $50 at each visit/day until it has been met.
- Since you may see us multiple times in a week, we will accept one payment at the beginning of the week.
- If you have a balance at discharge, we will set you up on a 3 month payment plan.
- To make payments easier, we accept MasterCard, Visa, Discover, check, or cash.
- Returned checks will result in a $20 fee applied to your account.
- Failure to make payment may result in discontinuation of services and balance submitted to collection agency at which time you will be responsible for all cost of collection including attorney fees and collection fees up to 35% of balance. Such fees will be added and collected by the agency immediately upon referral of your account to collection agency.
- If you feel there has been an overpayment of services and a refund is due, please contact our billing team at 270-408-2124.

TIPS TO MAKE YOUR THERAPY SUCCESSFUL

- We do our best to begin treatment on time; therefore, to maximize your treatment, please arrive on time.
- Sign in at the front desk at arrival.
- If you wait more than five minutes past your scheduled appointment time, please advise our front desk.
- Attend ALL appointments. Consistent attendance provides the best results!
- You will be given an Atlas folder. Please bring to each visit with a copy of your appointments and your receipts in case we need to review a document with you.
- Pay co-pay/co-insurance/deductible and discuss any schedule changes with the front office.
- You may wait in the waiting room or in our child friendly “Atlas Kids” waiting area if you have children. Our front office can direct you to this area.
- If you have additional people with you, they will be able to wait in our waiting area unless you have made prior arrangements with your treating therapist. This is for patient privacy and safety.
- Perform your home exercise program as directed by your therapist to reach maximum benefit.
- In case of inclement weather, Atlas will post any changes to our clinic hours on Instagram, FB, and Twitter. Follow us on social media for other helpful posts!
- Due to other patients’ allergies and sensitivities, please refrain from wearing perfumes, cologne or scented lotion.
- Wear comfortable clothing for your therapy visit.
- During your appointment, we kindly request that you refrain from cell phone use.

HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At Atlas Physical Therapy, LLC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 03/01/2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Atlas Physical Therapy, a record of your visit is made. Typically, this record contains your symptoms, examination and test results; diagnoses, treatment, and a plan for future care or treatment. This information often referred as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating medical health professionals
- A source of data for medical records
- A source of information for public health officials charged with improving the health of this state and nation
- A source of date for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to; ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Atlas Physical Therapy, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided 45 CFR 164.528
- Request communication of your health information by alternative means or alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.528
- Revoke your authorization to use or disclosure health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

Atlas Physical Therapy is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclosure your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM
If you have questions and would like additional information, you may contact our Privacy Officer at 270-443-0681.
If you believe your privacy right has been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights ● U.S. Department for Health and Human Services ● 200 Independence Avenue S.W.● Room 509F, HHH Building ● Washington, D.C. 20201

EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS
We will use your health information for treatment. For example, Information obtained by a nurse physician, or other member of the health care team will be recorded in your record and used to determine the course of treatment that should work best for you, how you are responding to treatment and document any actions taken.

We will use your health information on payments. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operation. For example: Members of the medical staff or management may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, contracted computer support, etc. When these services are contacted, we may disclose your health information to our business associates so they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and your general location.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Researchers: Researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Marketing: We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing, surveillance information to enable product recalls, repairs, or replacement.
Workers Compensation: we may disclose health information to extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for purposes required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Language Assistance Service

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the care we are providing.

Spanish
Tomaremos acciones razonables para proporcionar servicios de asistencia lingüística gratuitos a aquellas personas cuyo lenguaje escuchemos frecuentemente en nuestro consultorio y que no hablen un inglés lo suficientemente bueno como para hablar con nosotros sobre el servicio que suministramos.

Chinese
我�将有序地做到提供免�的�言服�使我�能听懂英�不好的人向我�咨�有骾牙�理

German
Wir werden angemessene Schritte unternehmen, um denen eine gebührenfreie Sprachunterstützung zu bieten, die Sprachen sprechen, die wir möglicherweise in unserer Praxis hören, die aber kein Englisch sprechen, das gut genug ist, um mit uns über die Zahnpflege zu sprechen, die wir anbieten.

Vietnamese
Chúng tôi sẽ thực hiện các bước cần thiết để cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người giao tiếp bằng những ngôn ngữ mà chúng tôi có thể nghe thấy tại phòng khám của mình và cho những người không có đủ trình độ tiếng Anh để thảo luận về dịch vụ chăm sóc nha khoa mà chúng tôi đang cung cấp.

Arabic
سوف نقوم باتخاذ خطوات معقولة من أجل توفير خدمات المساعدة اللغوية بدون تكلفة للأشخاص الذين يتحدثون لغات أخرى من المرجح أن نستمع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد بما يكفي للتحدث معنا حول الرعاية التي نقدمها. يتعلق بر عاية الأسنان التي نقدمها يمكنهم من التحدث إلينا فيما

Serbo-Croatian
Предузећемо разумне кораке да обезбедимо бесплатну преводилачку помоћ за особе које говоре језике са којима се током рада чешће сусрећемо, а који не говоре енглески довољно добро да би могли да разговарају са нама о стоматолошкој услузи коју пружамо.

Japanese
実際に練習の中で耳にするく可能性がある言語を話す人々で、弊社が提供している歯科治療について、英語がそ れほど上手でない人々に、無償の言語支援サービスを提供するために合理的な措置を講じるつもりです。

French
Nous prendrons les mesures raisonnables pour fournir des services d'assistance linguistique gratuits pour les individus qui parlent des langues que nous sommes susceptibles d'entendre durant nos séances et qui ne parlent pas suffisamment bien l'anglais pour discuter avec nous concernant les soins dentaires que nous fournissons.

Korean
저희는 적절한 조치를 통하여 언어 지원 서비스를 무료로 제공할 것입니다. 다만, 실제로 저희에게 관심이 있는 언어를 쓰지만 저희 치아 관리 서비스에 대해 의견을 줄 수 있을 만큼 영어로 의사소통이 원활하지 않는 경우로 한정합니다

Pennsylvanian Dutch
Mir zelle unser Beschtes browiere fer Hilf griege fer ennich ebber as Druwwel hett fer verschtehe was mer an schwetze is in Englisch weeich Zaahdokteres do. Die Hilf, as mer aabiede kennt, deet nix koschte.

Nepali
हामीले गराउने बारेमा कुरा र हामीले स ु भाषाको ला ग सेवा नश ु गराउन हामीले ।

Cushite
Wayita hojjii keenyatti Afaanota garaa garaagaraa namoota dubbatani fi tajaajila yaalaa nuti kenninuuf kan nu dandeessisu namoota dandeettii Aaan Ingilliffaa gahaa ta'e hin qabneef deeggarsa afaanii kanfaltii irraa bilisa ta'e kennuudhaaf tarkaanfii bu'a qabeessa ta'e ni fudhanna.

Russian
Мы принимаем необходимые меры, чтобы предоставить бесплатные услуги переводчика для общения на языках, с которыми мы сталкиваемся в нашей практике с клиентами, которые не владеют английским языком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.

Tagalog
Gagawin namin ang mga makatwirang hakbang para maibigay namin ng walang bayad ang mga tulong na serbisyo sa wika para sa mga taong nagsasalita ng mga wikang karaniwan naming naririnig sa aming pagsasagawa at sa mga hindi bihasa sa pagsasalita ng Ingles na sasangguni sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

Bantu
Tuzofasha ata kiguzi abo bavuga indimi twumva mu kazi kacu kandi batobasha kuvugana natwe Icongereza neza kuri ivyo bijanye n'ubuvuzi dutanga ku ndwara z'amenyo