Phone: (850) 348-1899 Fax: (850) 396-6207

Date: _____

PATIENT INFORMATION

Patient's Name: _____ Patient's Birthdate: _____

Parent / Guardian Names: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Work Number: _____ Cell Phone Number: _____

Email: _____

Primary Physician and Clinic Name: _____

Clinic Phone Number and Address: _____

Primary Insurance: _____ Policy Holder: _____

Policy Number: _____ Sponsor's SSN Tricare Only: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Number: _____ Sponsor's SSN Tricare Only: _____

FAMILY BACKGROUND

Mother's Name: _____ Employment: _____

Father's Name: _____ Employment: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Name(s) of Siblings and age: _____

_____

Do any of the siblings have speech / hearing / developmental problems? YES NO

What language(s) are spoken in the home? _____

Child lives with (check one): _____ Birth Parents _____ Foster Parents _____ Adaptive Parents

_____ One Parent _____ Other _____

MEDICAL HISTORY

Were there any pregnancy and / or delivery complications? YES NO

If *yes*, please explain: _____

Length of pregnancy: _____ Was prenatal care received? YES NO

The delivery was: _____ Induced _____ Vaginal _____ C-Section _____ Emergency C-Section

Mother's age at birth: _____ Child's Birth Weight: _____

Was the child discharged with the mother? YES NO

If *No*, please explain: _____

After delivery did your child have any complications? YES NO

If *yes*, please explain: _____

Does your child have a medical diagnoses or medical concerns? YES NO

If *yes*, please explain: _____

_____

Has your child been hospitalized and / or had any medical procedure performed? YES NO

If *yes*, please explain: _____

List all known allergies (seasonal, food, medications, latex, etc.)_____

_____

List of current medications and reason for medications: _____

_____

Has your child received any diagnostic testing? YES NO If *yes*, type of test _____

When was the test performed? _____ Results: _____

YES NO	History of Ear Infections	If yes, how often:
YES NO	Child have PE Tubes	If yes, date of procedure:
YES NO	Hearing Tested	If yes, did your child PASS or FAIL
YES NO	Vision Tested	If yes, did your child PASS or FAIL

Do you have concerns with your child's hearing / vision? YES NO

If *yes*, please explain: _____

_____

Is your child currently being seen by a neurologist? YES NO

If *yes*, please provide neurologist and clinic name: _____

DEVELOPMENTAL HISTORY

Please state the age your child mastered each of the following milestones:

	Started babbling		Able to sit alone
	Fed self; finger foods		Able to crawl
	Said first word		Walk without assistance
	Put two words together		Tiolet trained

Does your child use, or have previously used a pacifier? YES NO If *yes*, for how long? _____

Formula or Breast Fed / Feeding: _____ Age when started eating solids: _____

Supplement Diet: YES NO If *yes*, what do you supplement with: _____

Do you have concerns regarding your child's eating habits / feeding skills? YES NO

If *yes*, please explain: _____

What does your child use to drink? *(Mark all that apply)*

	Bottle		Sippy Cup		Straw Cup		Open cup

Does your child use utensils? YES NO *(Mark all that apply)*

	Spoon		Fork		Knife

Is your child a picky eater? YES NO Does your child gag or spit out food after chewing or swallowing? YES NO

If *yes*, please explain (what aversions to textures /flavors / etc.): _____

_____

Does your child eat meat? YES NO or N/A

Is your child on a special or restrictive diet? YES NO If *yes*, please explain: _____

_____

How does your child communicate their wants and needs? _____

Do most people understand your child? YES NO Does your child follow instructions? YES NO

What are the physician and / or teacher concerns regarding your child's development? _____

_____

Has your child, ever or do they currently receive speech, occupational, or physical therapy? YES NO

If yes, which discipline and where? _____

Does your child have an IEP? YES NO Does your child have IFSP? YES NO If either *yes*, we will need an updated copy.

Is there anything you would like to share with us regarding your child? _____

_____

_____

360 THERAPY, LLC. POLICIES

Please read and initial by the appropriate statements.

Attendance

_____ Consistent attendance is a vital part of your child's therapy progress. We ask that you respect our time by providing our office with a 24 hour cancellation notice. A cancellation the day of appointment will be accepted in emergencies or illness, however please notify our office as soon as possible.

_____ If you cancel your child's appointments often, your child's status will be reviewed to determine if we will be discharging them from services for poor attendance. If circumstances are making it difficult for you to attend, please discuss this with our office immediately. We may need to find another appointment time that suites your needs**.**

_____ We realize life can be very hectic and you may have many appointments to maintain; for this reason we allow 1 No Show without penalty (a No Show is a missed appointment without prior notice). If you have 3 consecutive No Shows you will be taken off the schedule. You will receive a notification from our office indicating this action.

Payment for Services

_____ The responsible party authorizes 360 Therapy, LLC, to provide therapy services to my child (patient) in accordance with the orders provided by the patient's physician. It is understood that a licensed therapist employed by 360 Therapy, LLC, will complete the services provided. The responsible party gives permission for the patient to receive therapy services provided by 360 Therapy, LLC.

_____ You are responsible for knowing your health insurance benefits. 360 Therapy, LLC, will verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial obligation. The responsible party understands that the verification of benefits is not a guarantee of payment and that they are responsible for all charges not paid by insurance company.

_____ The responsible party authorizes the release of information pertaining to the patient's diagnosis, and course of treatment to 360 Therapy, LLC, by the patient's physician, and any other therapy service providers involved in the patient's care. The responsible party also authorizes the release of information to the patient's physician, and any other agencies related to reimbursement issues.

_____ The responsible party authorizes any insurance carrier that provides insurance coverage for the patient, to make direct payments to 360 Therapy, LLC, for any therapy services rendered. The responsible party will accurately inform 360 Therapy, LLC, of the patient's insurance coverage.

_____ The responsible party understands the patient's insurance company may mail you a copy of the explanation of benefits (EOB) and/ or send a check directly to the member, any checks or EOB's you receive from an insurance company for services rendered by 360 Therapy, LLC, are due immediately to the provider upon receipt.

_____ The responsible party understands it's their responsibility to inform 360 Therapy, LLC, of any changes in address, phone number, or insurance coverage immediately. Failure to do so could result in incorrect processing of insurance claims thus making the parent / guardian responsible for any unpaid claims.

By signing below, you are stating you have read, understand, and agree to comply with all 360 Therapy, LLC, policies.

_____ _____

Signature of Parent / Guardian Printed Name of Parent / Guardian

CONSENT OF TREATMENT

I,_____(Parent / Guardian) consent 360 Therapy, LLC, to evaluate and provide therapy services to _____(Patient Name) as prescribed by the physician. I also authorize payment directly to 360 Therapy, LLC, of the individual or group insurance benefits specified and otherwise payable to me. I understand I am fully responsible to 360 Therapy, LLC, for all charges NOT paid by my insurance provider. 360 Therapy, LLC, is authorized to release to said insurance companies any and all information listed above and / or medical records.

_____ _____

Signature of Parent / Guardian Date

_____

Print Name of Parent / Guardian

Acknowledgement of Receipt of HIPAA Notice

By signing below you are acknowledging the receipt of this notice. The intent of this privacy notice is to make you aware of the uses and disclosures of your child's protected health information and your privacy rights. The delivery of your child's health care services will in no way be conditioned upon your signed acknowledgement.

_____ _____

Signature of Parent / Guardian Date

WAITNG ROOM DISCLOSURE

I understand that 360 Therapy, LLC, will provide speech therapy for my child in the clinic, where other families may be present in waiting room area who may hear health information regarding my child.

_____ ***Yes, I agree*** for 360 Therapy, LLC, staff to discuss my child's treatment sessions and progress in the waiting room.

OR

_____ ***No, I DO NOT*** agree for 360 Therapy, LLC, staff to discuss my child's treatment sessions and progress in the waiting room.