Idaho State University

ISU Physical & Occupational Therapy Associates
1311 East Central Drive, Meridian, ID 83642
Phone: 208.282.2590 / Fax: 833.499.1813

Pediatric Patient Demographics

Patient Name: _____ **DOB:** _____

Parent/Guardian: _____ **Sex:** ☐ Male ☐ Female

Address: _____ **Guardian SS No:** _____

_____ **Phone:** _____

Pediatrician: _____ **Office Phone:** _____

Referred By: **Primary Language:**

Insurance Information

Insurance Provider(s): (Please check all that apply)

☐ Blue Cross ☐ Regence BS ☐ Medicare ☐ Medicaid ☐ Pacific Source

☐ Select Health ☐ VA ☐ Ameriben ☐ UHC ☐ Tricare

☐ Private Pay ☐ Student Health ☐ Other: _____

Primary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **DOB:** _____

Secondary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **DOB:** _____

Address: (if different from above) _____

Employer: _____ **Student Status:** ☐ FT ☐ PT

Billing Policy

We bill most insurance companies, but are unable to bill Medicare and Medicaid when students are providing services. We recommend a physician's referral or prescription for services. All co-pays will be due after insurance has been billed and processed. If you do not have insurance and have limited financial resources, you may be able to qualify for a discount. If you qualify for a fee reduction, a partial payment may be due at the time of service. At a minimum, payments must be made monthly. Accounts past due more than 90 days will be sent to collections and any cash discounts applied will be removed and you will be responsible for regular therapy pricing.

Consent

I authorize Idaho State University to release information necessary to process insurance claims on my behalf. I understand that I am responsible for all co-pays, co-insurance, deductibles, and non-covered charges and understand the billing policy as stated above. I also understand that supervised graduate students may participate in the evaluation and treatment of the patient as part of their educational program, and hold ISU harmless for any incident related to this treatment.

Signed By: _____ **Date:** _____

Parent/Guardian or Responsible Party

Idaho State University

ISU Physical & Occupational Therapy Associates
1400 Terry Dr., Bldg. 63, Pocatello, ID 83209
Phone: 208.282.2590 / Fax: 833.499.1813

Pediatric Patient Profile

Patient Name: _____ **DOB:** _____

School: _____ **Grade:** _____ **Age:** _____

Parent/Guardian: _____

Emergency Contact: _____ **Phone No.:** _____

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

Is it ok for us to leave a message regarding your child's treatment at the following #s?

Home: ☐ Yes ☐ No **Cell:** ☐ Yes ☐ No

Reasons for Rehabilitation

Diagnosis/Conditions/Reasons you are seeking rehabilitation services: _____

_____

_____

Your Primary goal for therapy is to be able to? _____

_____

_____

Health History

Birth History: _____

_____

Developmental Milestones: (At what age did your child independently achieve)

Sitting Up: _____ Babbling: _____ Put Words Together: _____

Crawl: _____ Eat Solid Foods: _____ Understood by Strangers: _____

Walk: _____ 1st Word: _____ Toilet Trained: _____

Current No. of Words: _____

How much is your child understood by family? ☐ None ☐ Some ☐ Most ☐ Totally

How much is your child understood by strangers? ☐ None ☐ Some ☐ Most ☐ Totally

Medical Issues:

Does your child now have (or have you had) any of the following conditions? Please check all that apply.

Ear Infections	☐ Y	☐ N	Stress Disorders	☐ Y	☐ N	Stroke	☐ Y	☐ N
Tongue Thrust	☐ Y	☐ N	Developmental Delay	☐ Y	☐ N	Seizures	☐ Y	☐ N
Hoarseness	☐ Y	☐ N	Diabetes	☐ Y	☐ N	Pneumonia	☐ Y	☐ N
Cleft Repair	☐ Y	☐ N	PE/Ear Tubes	☐ Y	☐ N	Asthma/Hay Fever	☐ Y	☐ N
Tonsillectomy	☐ Y	☐ N	Headaches/Migraines	☐ Y	☐ N	Swallowing/Feeding	☐ Y	☐ N
Head Injury	☐ Y	☐ N	Concussion	☐ Y	☐ N	Other: _____	☐ Y	☐ N

How would you describe your child's general health? ☐ Good ☐ Fair ☐ Poor

If fair/poor, please explain: _____

_____

_____

List any dietary restrictions (diabetic, food allergies, etc.): _____

_____

Are there any other health problems that you would like us to know about? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does your child use a wheelchair, walker, or other assistive device for mobility? ☐ Yes ☐ No

If yes, identify which type of device: _____

Has your child had any previous surgeries? ☐ Yes ☐ No If yes, please explain below.

	Surgery/Procedure	Month/Year
1.		
2.		
3.		
4.		

Does your child have any allergies? ☐ Yes ☐ No If yes, please list any allergies and the reaction your child experiences to each below (e.g., allergies to medications, latex, foods, products, etc.)

	Allergen	Reaction
1.		
2.		
3.		
4.		
5.		

Medications:

Is your child currently taking any medication? ☐ Yes ☐ No If yes, please list below.

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Previous Therapies:

Type of Therapy	Dates	Agency	Name of Therapist
Speech Therapy			
Physical Therapy			
Occupational Therapy			
Psychological/Counseling			
Other Rehab			

Special Needs: (Please check all that apply)

Vision: ☐ No Problems ☐ Glasses/Contact Lenses ☐ Visual Difficulties ☐ Glasses for Reading ☐ Require Enlarged Print

Communication: ☐ No Problems ☐ Difficulty Reading ☐ Difficulty Writing

☐ Communication Needs/Devices/Assist, please specify: _____

_____

Hearing: ☐ No Problems ☐ Hearing Aid(s) ☐ Difficulty Hearing

Areas of Concern:

Production of Speech Sounds	☐ Yes	☐ No	Voice	☐ Yes	☐ No
Understanding/Following Directions	☐ Yes	☐ No	Stuttering/Fluency	☐ Yes	☐ No
Understanding Questions	☐ Yes	☐ No	Understanding/Speaking English	☐ Yes	☐ No
Expressing Ideas/Wants/Needs	☐ Yes	☐ No	Pragmatics/Social Language	☐ Yes	☐ No

Below are words to describe your child's personality and behavior. Circle all that apply.

Happy	Aggressive	Depressed	Enthusiastic	Friendly
Warm	Independent	Energetic	Distractible	Jealous
Tense	Prefers to be Alone	Dependent	Affectionate	Relaxed
Critical	Easily Fatigued/Tired	Directive	Can't Sleep	Impatient
Shy	Vigorous	Calm	Irritated	Angry

List description(s) not listed above: _____

Interests/Activities:

How does your child feel about therapy? _____

How does your child feel about unfamiliar people/situations? _____

How does your child transition? _____

Tips that help you with transitions? _____

How does your child typically communicate with you? _____

What are your child's favorite things? _____

What are your child's favorite activities/hobbies? _____

What are your child's favorite motivators? _____

What are your child's least liked things? Avoidance? _____

How does your child react to them? _____

Is your child aware of his/her communication difference? _____

Is your child concerned about his/her communication difference? _____

Is there anything else you would like us to know that would help us to best serve your child's needs?

_____

_____

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Consent for Participation

I, _____, give permission for the faculty and students of Idaho State University Physical & Occupational Therapy to use information gathered from my participation for educational training and research. I understand that students, under the supervision of the fully licensed faculty, will be observing and working with me as part of their training.

I understand that I can withdraw from my participation at any time during this experience and revoke my permission to use the information pertaining to my case. If I elect to withdraw and revoke my permission, I will inform the faculty member whose signature appears below or the department chairperson of this action in writing. I further understand that a copy of this form will be given to me upon my request, and the original will be kept on file for the period of five (5) years in the Department of Physical and Occupational Therapy.

I am aware that fees for services I received will be collected by the clinic on the day of treatment unless otherwise arranged with the clinic receptionist or clinic director. I further understand that should I need to cancel an appointment, I must provide 24-hr notice to the clinic by calling (208) 282-2590 to avoid being billed a $10.00 fee for not keeping my scheduled appointment.

_____ _____

Print Name of Patient or Personal Representative *Date*

_____

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Consent for Participation in Publicity Endeavors

I authorize that my protected health information in the form of photographs and video clips may be used by ISU Physical & Occupational Therapy Associates for publicity purposes. The photographs and/or video clips may be on the ISU Physical & Occupational Therapy Associates website, at job fairs, recruiting endeavors, and other events to recruit students to, or promote the professions of physical and occupational therapy studies for the Department of Physical & Occupational Therapy at Idaho State University.

The photographs and video clips may be used for the following purposes:

- To recruit professionals into the fields of physical and occupational therapy studies.
- To promote the Department of Physical & Occupational Therapy.
- To inform potential patients of the services offered at the ISU Physical & Occupational Therapy Clinic at Idaho State University.

This authorization will be used by the Department of Physical & Occupational Therapy at Idaho State University for a period not to exceed 10 years from the date of this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to ISU's Privacy Officer:

ISU Privacy Officer: General Counsel
921 S. 8th Avenue, Stop 8410
Pocatello, ID 83209
(208) 282-3022

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative	*Witness Signature*
Print Name of Patient or Personal Representative	*Print Name of Witness*
Date	*Date*
Description of Personal Representative's Authority or Relationship to the Patient	

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Authorization to Obtain Emergency Medical Treatment

I authorize the ISU Physical & Occupational Therapy Associates to obtain emergency medical treatment at any hospital for the individual listed below. I agree to be fully responsible for any costs related to the said treatment, and to hold harmless Idaho State University of any such costs.

_____ _____

Print Name of Patient or Personal Representative *Date*

_____ _____

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney

☐ Other: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Physical & Occupational Therapy Associates Notice of Privacy Practices.

_____ _____
Print Name of Patient or Personal Representative *Date*

_____
Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices? ☐ Yes ☐ No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:

   ☐ Patient/individual refused to sign _____ (Date of Refusal).
   ☐ Communication barriers prohibited obtaining an acknowledgement.
   ☐ Legal representative not available.
   ☐ Patient bypassed registration.
   ☐ An emergency situation prevented ISU from obtaining an acknowledgement.
   ☐ Other: _____
   _____

Completed By: _____ _____
Signature Date