GEARY
rehabilitation and fitness center

Pediatric Therapy
Patient Demographics

PATIENT INFORMATION					
First Name:	Last Name:	Middle:	Sex: (circle) Male Female	Date of Birth:	Age:
Primary Phone: □ Cell □ Home ( )	Alternative Phone: □ Cell □ Home ( )	Email Address:			
May we text appointment reminders to the provided cell phone: □ Yes □ No	May we leave a voicemail to the provided cell/home phone: □ Yes □ No	May we email PHI/ePHI to the provided email address: □ Yes □ No			
Street Address:	APT #	PO Box	City, State, ZIP Code:		
Guardian #1 Name:	Primary phone: □ Cell □ Home ( )				
Guardian #2 Name:	Primary phone: □ Cell □ Home ( )				

EMERGENCY CONTACT		
Name:	Relationship to Patient:	Phone: ( )

INSURANCE INFORMATION		
PRIMARY INSURANCE		
Policy Holder's Name:	Insurance Name:	
Policy Holder's Social Security Number:	Policy Holder's DOB:	
Policy/ID #:	Group #:	Effective Date:
SECONDARY INSURANCE		
Policy Holder's Name:	Insurance Name:	
Policy Holder's Social Security Number:	Policy Holder's DOB:	
Policy/ID #:	Group #:	Effective Date:

Information below is **REQUIRED**; please provide name of responsible party signing consent to treat:		
Name of Guarantor:	Relationship to Patient:	SSN:
Date of Birth:	If address or phone number is different from patient:	

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Notice of Policies

101 N. Washington St.
Junction City, KS 66441
Phone: 785.762.3350
Fax: 785.762.3920

CANCELLATION / NO SHOW POLICY

●Due to our one-on-one treatments, missed appointments have a significant impact on your/or your family member's therapy, the clinic, and other patients. Please, provide our office **with 24-hour notice to change or cancel an appointment**.

● Please arrive 5 minutes early for your scheduled appointments, late arrivals may not be seen due to time constraints.

● Patients will attend 80% of their schedule treatment sessions within a **three (3) month period**. This also includes:

- Three (3) consecutive missed appointments
- Three (3) consecutive 14+ minutes late arrivals
- Failure to contact our therapy office to cancel, due to inclement weather
- Two (2) No Shows

● Failure to meet the above criteria will require the patient to be placed on stand-by appointments only. The patient and/or family would be responsible for calling our office weekly to schedule additional appointments.

● We are open Mon-Fri except for: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day & Christmas Day.

★ _____ *(guarantor initials)*

CONSENT FOR TREATMENT

● I understand that I may have a condition requiring physical examination and/or medical treatment. I hereby voluntarily consent to such examination and treatment. I further acknowledge that no guarantees have been made to me as to the results of treatment provided by Geary Rehabilitation and Fitness Center. I also acknowledge that consent for examination and treatment does not constitute a medical diagnosis. Parent/Guardian must stay on premises during all treatment sessions.

★ _____ *(guarantor initials)*

FINANCIAL & PAYMENT AUTHORIZATION

● It is your responsibility to understand your insurance plan limitation, benefits, deductibles, co-pays and co-insurance amounts.

● You are responsible for payment of all amounts not covered by your insurance.

● If any past due balance is not paid at the time of your next appointment, you may be required to reschedule until payment is made.

● If you are unable to comply with our policy, payment arrangements can be made by calling our office.

● I authorize that the payment of my insurance benefits be made directly to Geary Rehabilitation and Fitness Center for all services rendered. If I am paid directly, I will promptly pay Geary Rehabilitation and Fitness Center all monies paid to me.

● I understand and agree that I am responsible for verifying my own insurance benefits. I agree to pay in full all charges shown on my billing statement upon receipt of the statement, unless other payment arrangements are made. It is agreed that payment will not be delayed or withheld because of any insurance claims pending or litigation. All process of insurance is assigned to this office where applicable. A copy of this assignment is as valid as the original. In the event legal action should become necessary to collect unpaid balance due for any services rendered, I agree to pay reasonable attorney fees or such costs as the court determines proper.

● I certify that the information I have provided Geary Rehabilitation and Fitness Center for payment including, but not limited to, related accident, illnesses, or other insurers is accurate and truthful.

● **If you have a set co-pay amount, that amount will be collected at each visit.** **CO-PAY AMOUNT: _____**

★ _____ *(guarantor initials)*

NOTICE OF PRIVACY PRACTICES

● A copy of the Notice of Privacy Practice of Geary Rehabilitation and Fitness Center and Patient Rights and Responsibilities are available online at www.gearyrehab.com/terms-policies or you may request a hard copy. I acknowledge that I have had the opportunity to read this document.

★ _____ *(guarantor initials)*

AUTHORIZE

Signing below indicates you understand and agree to the terms of the Notice of Policies.

Patient Name _____

★ _____ _____ _____

Printed Name of Guarantor **Signature of Guarantor** **Date**

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Pediatric Case History

PATIENT INFORMATION	
Child's full name:	DOB:
Does your child live with both parents:	Is your child adopted: □ Yes □ No *If yes, when:*
What language(s) are spoken in the home:	What is your child's primary language:

Who is the daytime caregiver(s) for the child *(please mark all that apply):*

□ Parent □ Nanny □ Daycare program □ Family Member □ Family member □ School

□ Baby Sitter □ Other (specify):

BACKGROUND INFORMATION

If applicable, describe your impression of your child's motor and/or sensory difficulties:

If applicable, describe your impression of your child's speech and/or language difficulties:

If applicable, has the difficulty changed since it was first noticed:

Do you have any concerns about your child's ability to chew or swallow food or liquid: □ Yes □ No

If yes, please describe:

Have you noticed any unusual eating patterns for you child: During infancy: □ Yes □ No Currently: □ Yes □ No

If yes to either, please describe (such as specific food preferences, chewing or swallowing problems, etc.):

PREGNANCY AND BIRTH

Child's birth weight:	Was the child born prematurely: □ Yes □ No *If yes, how many weeks:* Was the child placed in NICU: □ Yes □ No *If yes, how many weeks:*

Were there any complications during pregnancy or delivery: □ Yes □ No

If yes, please specify:

During the first month was your child:	**Yes**	**No**	**If yes, for how long?**
Cyanotic (blue)			
Jaundiced			
In an incubator			
Having difficulty with sucking or swallowing			
Other (please specify)			

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Pediatric Case History Continued

DEVELOPMENAL HISTORY Motor Milestones: Give the approximate age at which your child began to demonstrate the following activities:									
When was your child first able to:	**Birth- 6 mos**	**6 mos- 1yr**	**1-2 yrs**	**2-3 yrs**	**3-4 yrs**	**4-5 yrs**	**5-6 yrs**	**Emerging**	**Unable**
Roll over									
Sit up independently									
Crawl									
Stand alone									
Walk alone									
Feed self-finger foods									
Feed self-using utensils									
Cut food into bite size									
Bathe Self									
Dress self									
Put on shoes									
Tie shoes									
Put on coat									
Zip coat									
Potty trained for urination									
Potty trained for bowel movement									

SPEECH MILESTONES				
Give the approximate age at which your child began to perform the following activities:	**9 mos – 18 mos**	**18 mos – 2 years**	**2 years – 3 years**	**4 years or after**
What was your child's first word & when				
Use single word				
Combine words (i.e., "me go", daddy shoe" etc.)				
Use simple questions (i.e., "where's doggie", etc.)				
Engage in conversation				

FAMILY HISTORY			
Has anyone in your family had:	**Yes**	**No**	**If so, please describe**
Speech challenges			
Language challenges			
Delayed onset of speech and language			
Learning challenges			
Behavioral challenges			
Seizures			
Chronic illness of any kind			

EDUCATIONAL HISTORY	
Current school or program:	Current school district:
Current grade level:	
If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed for your child: □ Yes □ No *If yes, describe the most important goals:*	
How does your child interact with others (i.e., shy, aggressive, uncooperative, etc.):	

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Pediatric Case History Continued

MEDICAL HISTORY	
Please list any diagnoses that your child has been given by medical professionals:	
Is the child currently under medical treatment or taking medication: □ Yes □ No *If yes, please list:*	
Does your child have any food allergies: □ Yes □ No *If yes, please list:*	Does your child have any drug or latex allergies: □ Yes □ No *If yes, please list:*
When was your child's most recent hearing screening test and what were the results:	
When was your child's most recent vision test and what where the results:	
Has your child ever had a major surgery: □ Yes □ No *If yes, please explain:*	
Has your child ever received Botox injections or a Baclofen pump: □ Yes □ No *If yes, please explain (when, which muscle, physician, did the spasticity improve:*	

Does your child currently have or did your child previously have any of the following:				
Condition	**Yes**	**No**	**Age**	**Describe**
Visual defect				
Glasses				
Cleft palate				
Hearing aid				
Ear infections				
Skull fracture				
Concussion				
Measles				
Chicken pox				
Mumps				
Encephalitis				
Meningitis				
Pneumonia				
Impetigo				
Seizures				
Defect of tongue, jaw, teeth, or lips				
Emotional or behavior problems				
Other				

SENSORY PREFERENCES			
Does your child seek out or avoid:	**Seeks**	**Avoids**	**Indifferent**
Loud noises			
Difference food textures			
Different textures on their skin			
Being touched			
Spinning or swinging			
Jumping into or off of things			

Pediatric Case History Continued

SPECIALIZED SERVICES					
Has your child ever had special help from:	**Yes**	**No**	**In School**	**Outpatient**	**If so, please describe**
a Psychologist					
a Speech-Language Pathologist					
a Special Educator					
a Physical Therapist					
a Medical specialist (i.e. Neurologist)					
an Occupational Therapist					
an Audiologist					
Infant-Toddler Services					

CURRENT COMMUNICATION SKILLS

Rate your child's current communication skills by placing and X in the box that **best describes** your child in each of the four areas:

Understanding
- □ Responds only to gestures
- □ Able to follow 1-step commands
- □ Able to follow multi-step commands
- □ Able to follow conversation in noisy environments

Stuttering
- □ Normal
- □ Repeats and/or prolongs individual sounds, words or phrases

Expression
- □ Communicates primarily by pointing and gestures
- □ Communicates in single words or phrases
- □ Converses in simple sentences
- □ Converses at abstract or complex level

Speech
- □ Understandable only to parents, family and familiar persons
- □ Understandable to all people

EQUIPMENT

Do you use any specialized equipment with your child at home: □ Yes □ No
If yes, please describe:

Does your child wear any orthotic devices (AFO, hand splints, etc.): □ Yes □ No
If yes, please describe:

Does your child use an assistive device for mobility (walker, wheel chair, etc.): □ Yes □ No
If yes, please describe:

SUMMARY

Please list any other concerns not addressed above or additional information you think might be helpful, including any that you would like to have specifically addressed during the evaluation:

If applicable, what are your primary goals for you child during speech therapy:

If applicable, what are your primary goals for you child during occupational therapy:

If applicable, what are your primary goals for you child during physical therapy:

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