A

Patient Name_____

Patient Date of Birth_____ Gender: ☐ MALE ☐ FEMALE

Who is the primary insurance policy holder? (circle one) Patient Parent Other N/A

B **address**

Street Address_____ Apt #_____

City_____State_____Zip Code_____

C **contact**

Mother/Guardian:_____DOB:_____Occupation:_____

Phone: (c)_____ (w)_____Email:_____

Father/Guardian:_____DOB:_____Occupation:_____

Phone: (c)_____ (w)_____Email:_____

D **insurance**

If you selected patient as the primary policy holder skip to section E

Primary Insurance Policy Holder Name_____Date of Birth_____

Insured's address if different from patient _____

Policy Holder Social Security #_____or Drivers License #_____

E **Case Info**

Was the problem your child is receiving treatment for related to an injury? **Yes or no**

If yes, please explain._____

_____

F

Medicaid Only (Including Magnolia MSCAN/UHC MSCAN) If your insurance is not Medicaid, please skip to section G.

Medicaid guidelines require your child to have an appointment with their **referring physician** every 6 months to receive rehab services.

Please initial here acknowledging that you understand that you will need to take your child to their **referring physician** every 6 months for them to continue receiving speech therapy. _____

Please list individuals with which we may share information regarding your child's treatment:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorize Moye Physical Therapy to communicate information regarding my child's treatment with the above person(s) as needed.

_____

Parent/Guardian Signature

Child Case History Form

Date: _____

Please list all ages and relationships of others living in the home with the child:

_____

_____

Languages spoken in the home:_____
Have any family members had speech, language, hearing, or learning difficulties? □Yes □No
If yes, please explain:_____

Statement of Problem:
Please describe the concerns you have about your child's communication or feeding skills at this time:

_____

_____

_____

Birth History:

□ Full Term Pregnancy □ No Pregnancy or Birth Complications
□ If Premature (# of weeks): _____ Gestational Weeks: _____ □ Birth Weight: _____

Complications During Pregnancy/Delivery:

_____

_____

Medications Used During Pregnancy:

_____

□ Oxygen □ Feeding Tube □ NICU Length of time:_____

Medical History:

Referring Physician/Office:_____

Please list any medical diagnosis your child has received (ADHD, Autism, etc.)

_____

Childhood Illness, Hospitalizations and/or Surgeries: (include ages)

_____

_____

Past Medications: (please list ages)

_____

Current Medications:

_____

Past Therapies: (please list ages)

_____

Current Therapies:

_____

Allergies:_____

Date/Location of most recent hearing test/screening: _____

Results: Pass Fail Describe:_____

History of ear infections: Yes No If Yes, how many and at what age:
_____

Does the child have PE tubes? Yes No Date received: _____
Name of ENT: _____

Next scheduled check up date with ENT: _____

Developmental History:

Please indicate ages at which your child:

_____sat unsupported _____crawled _____walked _____dressed self

_____was potty trained _____babbled _____used first word ____fed self_____used cup

Educational History:

Does your child attend School/Daycare: Yes No
Name/Location:_____

Grade: _____ Does your child have an IEP? □Yes □No (Please provide a copy at evaluation)
List any grades your child has repeated:_____
Please list special services/therapies your child receives at school:
_____

Feeding History:

Does your child have a history of feeding/swallowing difficulties? Describe
_____

Is your child on any special diet or thickened liquids?
Describe_____

List your child's preferred foods:
_____

List foods your child will not eat:
_____

Speech History:

How does your child usually communicate with you?(check all that apply)
□gestures □words □phrases □sentences □Other_____

Approximately how much of your child's speech do you understand?
□Less than 10% □25% □50% □75% □90-100%

Approximately how much of your child's speech do other people understand?
□Less than 10% □25% □50% □75% □90-100%

What are your goals for therapy?
_____
_____
_____

PATIENT AGREEMENT

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Moye Physical Therapy** to furnish medical care and treatment to _____(Patient Name) considered necessary and proper in diagnosing or treating his or/her physical and/or mental condition. Moye Physical Therapy reserves the right to discharge any patient for excessive cancellations or no shows.

BENEFIT ASSIGNMENT

I, the undersigned, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to entities doing business as **Moye Physical Therapy .** A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL POLICY

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Moye Physical Therapy.**

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for the services rendered to you.

I, the undersigned, understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Jeff Moye Inc. dba Moye Physical Therapy has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:

a) texting cell phone b) e-mail c) voice message to primary phone number

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____	_____
Name of Individual (Printed)	**Signature of Individual**	**Signature of Legal Representative** (e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed :_____ Witness: _____

The attendance policy for speech therapy is the following:

After your child has 2 "No shows" in a row, they will be removed from having a reoccurring appointment. If you want your child to continue speech therapy, you will need to call weekly and set up an appointment where there is availability on your therapist's schedule.

If your child's attendance falls below a 75% show rate, you will be given a written warning. If their attendance falls below a 50% show rate, your child will be removed from having a reoccurring appointment. If you want your child to continue speech therapy, you will need to call weekly and set up an appointment where there is availability on your therapist's schedule.

An appointment will be documented as a "No show" when less than 3 hours notice is given, OR completely missing the appointment without any notification.

An appointment will be considered a "cancellation" when you give at least 4 hours notice.

If you notify us that your child will not be at an appointment 7 days in advance, it will not be counted against their attendance rate.

If your therapist cancels your appointment this will not be counted against your child's attendance rate.

Please sign below acknowledging that you have read and understand the attendance policy.

_____ _____

Patient/Guardian Date