Peach State Pediatric Therapy, Inc.
REGISTRATION FORM

(Please Print)

Today's date:	Diagnosis:

PATIENT INFORMATION

Patient's name:	Gender: ☐ Male ☐ Female	Date of Birth:
Street address:	City:	State/Zip Code:
Social Security Number:	Home Phone:	Cell Phone:
Parent(s) Name:	Email Address:	
Pediatrician/PCP:	Pediatrician Phone:	Pediatrician Fax:
Pediatrician Street Address:	City:	State/Zip:
Referred by:		
Other Family Members Seen Here:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Responsible Party:	Birth date:	Address (if different):	Phone:
Relationship to Patient:	☐ Self ☐ Spouse ☐ Parent ☐ Other:		
Employer:	Employer address:		Employer phone no.:
Primary Insurance Company:			
Group #		ID #	
Claim Address:		Insurance Company Phone #	
Secondary Insurance Company:			
Group #		ID #	
Claim Address:		Insurance Company Phone #	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone Number:

The above information is true to the best of my knowledge.

Patient/Guardian signature	***Date***

4992 Bristol Industrial Way
Buford, GA 30518
Phone: (770) 904-6419 Fax: (770) 904-6418

PATIENT CONSENT AND POLICY AGREEMENT

_____ (initial) I. **Consent for Treatment**: I hereby authorize and voluntarily consent to Peach State Pediatric Therapy Inc., and its employees to provide the patient with basic treatments including medical and diagnosis procedures considered reasonably necessary by the patient's physician for the patient's current condition.

_____ (initial) II. **Uses and Disclosure of Health Information**: The patient's health record, including the original paper record and electronically stored health information is the property of Peach State Pediatric Therapy Inc. All patient care information shall be regarded as confidential and available only to authorized users. I consent to the disclosure of health record information to members of the medical, clinical, and professional staffs who have a right to access the information.

Peach State Pediatric Therapy Inc. uses health information about the patient for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care the patient receives. Peach State Pediatric Therapy Inc. may use or disclose identifiable health information without your authorization for several other reasons. Subject to certain requirements, Peach State Pediatric Therapy Inc. may give out health information without my authorization for public health purposes, auditing purposes, for research studies, and for emergencies. Peach State Pediatric Therapy Inc. provides information when required by law, such as for law enforcement in specific circumstances.

I understand in other situations that I will be asked for my written authorization before Peach State Pediatric Therapy Inc. uses or discloses any identifiable health information about the patient. I have the right to choose to sign an authorization to disclose information and later revoke that authorization for future uses. Peach State Pediatric Therapy Inc. may change their policies related to use and disclosure of health information at any time. Prior to Peach State Pediatric Therapy Inc. making any changes in their policy they will change the notice and have it accessible at their office for review or if additional copies are needed. For additional information related to privacy practices I may contact the privacy officer , Margaret Kuneyl OTR/L at (770) 904-6419. As an individual you have the right in most cases to:

-Look at/get copy of health information about the patient that Peach State Pediatric Therapy Inc. uses to make decisions about the patient.
-Request that incorrect or missing information be corrected or added respectively.
-Request in writing that Peach State Pediatric Therapy Inc. use or disclose patient information for treatment, payment, or related purposes except when authorized by, required by law, or emergency situations. Peach State Pediatric Therapy Inc. will consider this request but is not legally required to accept it. If I am concerned that my privacy rights have been violated or that I disagree with the decisions of Peach State Pediatric Therapy Inc. made about patient access information I can contact the privacy officer or send a written complaint to the US Department of Health and Human Services.

It is Peach State Pediatric Therapy Inc. legal duty to protect the privacy of the patient's information, provide this notice about information practices, and follow the information practices that are described in this notice.

_____ (initial) III. **Consent for Release of Information for Payment Purposes:**
I herby authorize Peach State Pediatric Therapy Inc. to release to any insurance carrier, employer, government or social service agency, or other payer or provider of medical benefits which may or will pay for any part of medical expenses incurred, any information pertaining to the patient's care, for the purpose

of evaluating and processing claims for payment for the patients care with Peach State Pediatric Therapy Inc. This is to include release to patient's physician for their ability to procure payment for services with Peach State Pediatric Therapy Inc. I further authorize the disclosing of information regarding the patient's medical care and/or encounter information to the designated utilization or peer review organization of the patient's insurer, employer, other payer, or collection agency as may be necessary to effectuate payment for the patient's care. This information may be released via electronic copy, hard copy, or fax.

_____ (initial) IV. **Guarantee of Payment/Billing Policy:** It is the parent/legal guardian's responsibility to disclose all known and potential insurance coverage sources. Peach State Pediatric Therapy Inc. will bill the patient's insurance company for rendered services as a courtesy. With this it is the patient's parent/legal guardian's responsibility to assist in the prompt receipt of payment from their insurance company. I understand that I must notify Peach State Pediatric Therapy Inc. of any changes in insurance coverage. Furthermore I understand that failure to do so will result in my responsibility for all accrued bills. I understand that I am responsible for the bill if existing insurance is terminated or service is not covered at the full rate of $160.00 per hour session and $350.00 per evaluation without exceptions.

I am aware that Peach State Pediatric Therapy Inc. may not be a participating provider with my insurance company. As a result coverage levels may be affected. I understand that it is my responsibility to contact the Member Services Representative with my plan for coverage determination. I am aware that an invoice will be given to me stating services rendered during a billing cycle and that I am responsible for paying any difference as outlined in my individual insurance plan within 30 days. Any invoice not paid in full within the 30 days will result in termination of treatment. Any invoice not paid within 90 days will be sent to a collection agency contracted with Peach State Pediatric Therapy Inc. Subsequent legal fees, collection fees, and penalties, will be added to invoice. The total of added fees may be in excess of the invoice total. I, the undersigned authorize the payment of patients medical benefits and/or government benefits as it relates to patients therapy services to Peach State Pediatric Therapy Inc.

_____ (initial) V. **Personal Valuables:** It is understood and agreed that Peach State Pediatric therapy Inc. shall not be responsible or liable for any loss, theft, misplacement, or damage of any valuables and personal belongings.

_____ (initial) VI. **Authorization to release and use photo/video:** I authorize and consent Peach State to take and use pictures/video of my child for teaching, quality improvements, research, marketing, and or presentation purposes without identifying the child.

_____ (initial) VII. **I have been provided a copy of Peach State Pediatric Therapy Inc. Privacy Policy**

_____ (initial) VIII. **Attendance/Cancellation Policy:** It is very important that you attend each and every scheduled appointment on time. Parent or legal guardian must stay on the premises for the entire length of the treatment. Therapy will be terminated if your child does not maintain a 75% attendance rate (6 out of 8 sessions or two sessions are missed without notifying the office or therapist. Cancellation must occur within 24 hours of your scheduled appointment. Do not bring your child if they are running a fever, vomiting, have diarrhea, or have an illness that is contagious (i.e. pink eye, chicken pox, etc.).

IX. I certify that I have read and understand this consent and have signed and initialed this consent in the capacity indicated below on the date indicated below.

_____ _____

Parent/Legal Guardian Signature **Date of Signature**

_____

Patient's name

4992 Bristol Industrial Way, Buford, GA 30518

PEACH STATE PEDIATRIC THERAPY INC. PRIVACY NOTICE

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information.
Please review it carefully
Effective Date 4/14/03

Any questions pertaining to this notice should be directed to Peach State Pediatric Therapy Inc. Privacy Officer at (770) 904-6419.

Who will follow this notice.
This notice describes Peach State Pediatric Therapy Inc.'s practices and that of:
- Any health care professional authorized to enter information into your chart
- Any member of a volunteer group we allow to help you while you are in the care of Peach State Pediatric Therapy Inc.
- All employees, staff, and other Peach State Pediatric Therapy Inc. personnel.

Our pledge regarding medical information:
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from Peach State Pediatric Therapy Inc. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.
The Law requires us to:
- Make sure that medical information that identifies you is kept private.
- Give this notice of your legal duties and privacy practices with respect to medical information about you
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you.
The following categories describe different ways that we use and disclose medical information:

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other medical personnel who are involved in your care. For example, referral information is taken from the patient, patient family, service coordinator, or physician office and this information will be given to the treating therapist.

For Payment: We may use and disclose medical information about you so that the treatment and service you receive at Peach State pediatric Therapy Inc. may be billed to and payment may be collected from you, an insurance company, or third party. For example, we submit requests for payment to your insurance company. Payment for your healthcare services may include certain activities that your healthcare insurance plan may undertake before it approves or pays for healthcare services we will render. This may include determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations: We may use and disclose medical information about you for Peach State Pediatric Therapy Inc. operations. These uses and discloses are necessary to run Peach State Pediatric Therapy Inc. and make sure that all of our patients receive quality care. For example, we obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, transcription services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services: We may use and disclose medical information to tell you about health related benefits or services that may be of interest to you.

Fundraising Activities: We may use medical information about you to contact you in an effort to raise money for Peach State Pediatric Therapy Inc. and its operations. If you do not want us to contact you for fundraising efforts, you must notify the privacy officer in writing.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who help pay for your care.

Research: Under certain circumstances, we may use and disclose your health information for research purposes.

As Required by Law: We will disclose medical information about you when required to dos o by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue or tissue donation and transplantation.

Public Health Risks: As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect: We may use and disclose medical information to public authorities as allowed by law to report abuse or neglect.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official for such things as court order, or in cases involving felony prosecutions, or the extent an individual is in the custody of law enforcement.

Website: If we maintain a website that provides information about our entity, this notice will be posted on the website.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by requesting it in writing.

Right to an Accounting of Disclosures: You have the right to request an "Accounting of Disclosures". This is a list of disclosures we made of medical information about you.

Right to Request Restrictions: You have the right to request in writing a restriction or limitation on medical information we may use or disclose about you for treatment, payment, or health operations. Peach State Pediatric Therapy Inc. is not required to agree to a request that is made.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example using a certain telephone number or by mail. We are not required to follow your request but will make every reasonable effort to do so, or find a mutually satisfactory alternative.

Right to a Paper Copy: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. To request a paper copy please contact the office at Peach State Pediatric Therapy Inc.

PEACH STATE PEDIATRIC THERAPY INC. RIGHT TO DENY ACCESS TO YOUR PROTECTED HEALTH INFORMATION

Peach State Pediatric Therapy Inc. may deny access to your protected health information if a licensed health care provider determines that releasing it could endanger you or someone else; your protected health information refers to a third party and releasing it could harm that person; or providing access to a personal representative could harm you or another person.

If you have been denied access based on the above circumstance you may appeal that decision. Under certain circumstance Peach State Pediatric Therapy Inc. may deny your request for access to your protected health information without giving you an opportunity to appeal that decision.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will have the new notice accessible at our office. You have the right to request this notice at any time by contacting the privacy officer at (770) 904-6419.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a written complaint with Peach State Pediatric Therapy Inc. or with the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosure of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to you.

Today's date: _____

HISTORY FORM

Child's Name: _____ Date of birth: _____

Child's Birth History:

1. How many weeks gestation was the child born? ____ weeks (40 weeks is typical)

2. The child was _____ lbs ____oz and _____ inches at birth

3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section

4. Please describe any complications or concerns during labor or delivery:

_____

_____

Infancy and Early Childhood:

Please describe any feeding problems:

_____

_____

Please describe any sleeping problems:

_____

_____

Did your child experience colic? ☐ Yes ☐ No

Did your baby dislike lying on stomach? ☐ Yes ☐ No

Did your baby dislike lying on back? ☐ Yes ☐ No

Did your baby become calmed by car rides or infant swings? ☐ Yes ☐ No

Did your baby become upset by car rides or infant swings? ☐ Yes ☐ No

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐ PT_____

☐ OT_____

☐ SLP _____

☐ Behavioral Therapist _____

☐ Psychologist / Psychologist _____

☐ Other:_____

Educational History

Is the child currently enrolled in daycare/school: ☐ Yes ☐ No

What is the name of the program? _____

What day(s) do they attend? _____

Child's Handedness: ☐ Right ☐ Left ☐ Ambidextrous ☐ No preference ☐ Not yet developed

If they receive any accommodations, please describe: _____

_____

_____

Child has IEP ? ☐ Yes ☐ No

Date of IEP Annual Review: _____

List Special Education Services and Service Providers:

_____

_____

Medical History

Is the child currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Does the child have any known allergies? ☐ Yes ☐ No

Describe: _____

_____

Does the child currently use any equipment? (communication device, walker, braces, stander, wheelchair, gait trainer, etc) Describe:_____

_____

Does the child have a history of ear infections, tubes, etc. or use hearing aides? ☐ Yes ☐ No

Describe: _____

_____

Does the child have any known hearing loss? ☐ Yes ☐ No

Does the child have any vision concerns? ☐ Yes ☐ No

Does the child wear glasses? ☐ Yes ☐ No

Surgeries/Procedures: (date and type)

_____

_____

_____

Developmental Milestones (please list age if remembered):

Roll Over _____ Sit alone _____

Crawling _____ Walking _____

Chew solid food _____ Drink from a cup _____

Say words _____ Say sentences _____

Does the child have any difficulty with the following Speech Therapy related tasks:

- ☐ Answering questions
- ☐ Grammar
- ☐ Understanding people
- ☐ Following directions
- ☐ Excessive drooling
- ☐ Chewing or eating
- ☐ Producing speech sounds
- ☐ Stuttering
- ☐ Reading
- ☐ Word retrieval
- ☐ Maintaining eye contact
- ☐ Remembering
- ☐ Transitions
- ☐ Social Skills

Does the child have difficulty with Occupational Therapy related tasks:

- ☐ School Skills(coloring, writing)
- ☐ Visual perception
- ☐ Sensory Processing
- ☐ Self-help activities(dressing, brushing teeth)
- ☐ Self-regulation
- ☐ Bowel/bladder management
- ☐ Potty training
- ☐ Feeding/utensil use
- ☐ Fine Motor
- ☐ Vision

Does the child have difficulty with Physical Therapy related tasks:

☐ Gross Motor ☐ Coordination

☐ Mobility ☐ Core Strength

☐ Balance ☐ Endurance

☐ Other Strength issues ☐ Frequent tripping and falls

☐ Ball Skills ☐ Pain

☐ Posture ☐ Range of Motion

☐ Other difficulties: _____

Please describe any of the above: _____

_____

Has the child experienced any difficulty with feeding or swallowing? If so, please describe: _____

_____

Social/Emotional Skills:

Describe how the child interacts with parents, siblings, or other family members:

_____

_____

_____

What are the child's strengths/weaknesses? _____

_____

_____

_____

What are the child's favorite activities? _____

_____

Describe how the child interacts with other children: _____

_____

Is there anything else that is important for us to know about the child?

_____

_____

_____

Person filling out the form: _____

Relationship to the child: _____

Patient's Name: _____ **Date of Birth:** _____

Questionnaire Completed By: _____ **Today's Date:** _____

Self-care:

1. **Bathing/Showering**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

2. **Bowel and Bladder Management**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

3. **Dressing**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

4. **Eating**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

5. **Feeding**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

6. **Functional Mobility**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

7. **Personal Device Care**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

8. **Personal Hygiene and Grooming**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

9. **Toilet Hygiene**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

Occupation:

1. **Rest and Sleep**

☐ I have no concerns in this area. My child receives _____ hours of sleep per day.

☐ I have concerns. My concerns are (please list):

_____

_____

2. **Education (School)**

☐ My child does not attend school.

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

3. **Work**

☐ My child does not work.

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

4. **Play and Leisure**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

5. **Social Participation**

☐ I have no concerns in this area.

☐ I have concerns. My concerns are (please list):

_____

_____

Additional Concerns:

Welcome to Peach State Pediatric Therapy

Dear Families, we're thrilled to have your family join us as your child embarks on their journey towards growth & development. Our dedicated team is here to support you every step of the way.

We offer three specialized therapy services: **Occupational Therapy, Physical Therapy,** & **Speech Therapy**. Each plays a unique role in helping your child thrive:

- **Occupational Therapy (OT):** OT focuses on enhancing your child's ability to perform daily activities. We help children develop fine motor skills, hand-eye coordination, and independence in tasks such as dressing, feeding, and engaging in play. We also assist in sensory integration to address sensory challenges that are hindering their occupational performance.
- **Physical Therapy (PT):** PT aims to improve your child's strength, balance, and coordination. We work on exercises that promote muscle development and mobility, helping to overcome any physical limitations. This includes activities to enhance walking, balance, and agility, allowing your child to move confidently.
- **Speech Therapy (ST):** ST focuses on developing effective communication skills. We work on areas such as speech articulation, sentence formation, language comprehension, and social skills. We also address feeding and swallowing issues, helping your child express themselves clearly and effectively.

We understand that each child is unique, and we are committed to tailoring our approach to meet their individual needs. We look forward to partnering with you in this important journey!

Warm regards,

Peach State Team

770-904-6419
admin@peachstatetherapy.com