Houston Spine & Rehabilitation Center
for Pediatric Therapy

CENTER FOR PEDIATRIC THERAPY

Personal Data:

Child's Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Child's Diagnosis: (if any) _____

Child's Primary Care Physcian: _____

Child's Referring Physician: _____

Family Information:

Mother's Name: _____ DOB: _____

Educatuion Completed through: _____ Occupation: _____

Employer: _____ City, State _____ Work Phone: _____

Father's Name: _____ DOB: _____

Educatuion Completed through: _____ Occupation: _____

Employer: _____ City, State _____ Work Phone: _____

Stepmother/Stepfather's Name (if applicable): _____

Educatuion Completed through: _____ Occupation: _____

Employer: _____ City, State _____ Work Phone: _____

Referral Information:

Who referred you to this facility?: _____

Please write a desciption of the child's problem as you see it. Please include any information which you feel may be helpful: _____

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Pregnancy and Birth:

Length of Pregnancy: _____ Baby's birth weight: _____ lbs _____ oz _____ length
Medications taken during pregnancy: _____
Describe: _____
Difficulties during pregnancy: _____
Difficulties during delivery: _____
Delivery Method (circle one): Vaginal Breech Forceps C-Section
Is the child adopted?: _____ If yes, at what age? _____

Pregnancy and Birth (continued):

Difficulties following birth:
- Trouble Breathing _____
- Turned yellow _____
- Turned Blue _____
- Required Oxygen _____
- Required incubation _____
- Trouble Sucking _____
- Incubation _____

Difficulties during infancy:
- Sucking _____
- Swallowing _____
- Sleeping _____
- Limp _____
- Rigid _____
- Irritable _____
- Colic _____
- Overactive _____

Length of stay at hospital: _____
Please list any other difficulties following birth or during infancy: _____
_____

Developmental History:

At what age did the following occur?:
- Sat up without help _____
- Crawled _____
- Walked _____
- Spoke 1st word _____
- Put words together _____
- Fed self _____
- Bladder Control _____
- Bowel Control _____
- Dressed Self _____
- Bed Wetting? Y / N

Was the child breast fed or bottle fed? _____ Any problems?: _____
Does the child have any problems with feeding/oral-mototr skills (i.e. chewing, swallowing, drooling, exxaggerated gag reflex) ? _____ If yes, please describe_____
_____
Were there periods when the child quit talking?: _____ Describe: _____
Does the child babble?: _____ At what age? : _____
Age when child combined two words? (for example, want cookie?) _____
Age when child combined three words? (for example, go bye-bye?) _____
Approximate # of words in vocabulary? _____

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Health and Medical History:

Childhood illnesses (check if yes, note frequency and age):

Ear infections	_____	Tubes ine ears	_____
Tonsilitis	_____	High Fevers	_____
Frequent Colds	_____	Respiratory Infections	_____

Allergies? (please list all): _____

Seizures? (if yes, when was the last one?) _____

Please list and descibe any other important injuries, illnessses and major operations and when they happened: _____

Has the child ever been to a dentist? Tongue or lip tear ever reported? _____

Has the child been to a neurologist? If yes, when and what were the results? _____

_____

What other therapies is the child receiving? _____

Has vision been examined? If yes, when and what were the results? _____

Does the child wear glasses? _____ At what age were they prescribed? _____

Please list all medications child is currently taking and what they were prescribed for: _____

_____

_____

Behavior:

How does he/she get along at home? _____

How does he/she get along at daycare/school? _____

How does he/she get along with other children? _____

How does his/her attittude toward daycare/school? _____

Difficulty sitting still? _____

Difficulty paying attention? _____

Other behavioral problems? _____

Describe the child's strengths and/or special interests? _____

Education:

If your child is not in school yet, where does he/she stay during the day? _____

If your child is in school, please complete the following:

Name of school: _____ Grade/Level: _____

Type of class (i.e. Regular, Special Education) _____

If special Education, what label was used to qualify child? (i.e. Learning disability)_____

Does your child receive therapy in school? If yes, who is his/her therapist? _____

Handedness (Complete either right or left with each activity):

Writing _____ Throwing a ball _____ Eating _____

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Family History:

Siblings: Name _____ DOB _____ Name _____ DOB _____
Name _____ DOB _____ Name _____ DOB _____

Other persons living in the same home and relationship to the child: _____

Language(s) spoken in the home: _____

Has anyone in the family ever had speech, language, swallowing, hearing or learning problems? If yes, what was the problem and who was it? _____

Personal Goals:

If your child requires therapy, what are your personal goals? What things would you like your child to learn? Please list goals in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Tactile:

Does or did your child:

Have a strong need to touch objects or people? _____

Excessively dislike having hair or face washed? _____

Avoid certain textures of food? _____

Dislike the feeling of certain types of clothing? If so, please explain. _____

Seem almost unaware of or "stoic" over painful experiences such as having shots, stitches, dental work? If so, please explain. _____

Often unaware of bruises, cuts, bleeding gashes from playing until someone brought it to his/her attention? _____

Were sleep patterns in infancy and/or childhood irregular? Please explain _____

Is it difficult to get your child to sleep, or comfort your child now? _____

Would you descibe your child as a quiet or active baby? _____

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Fine Motor:

Does or did your child:

Manipulate small objects easily? _____

Have difficulty with paper and pencil activities? Please give examples _____

_____

Have difficulty fastening and unfastening clothes? If so, what type of clothes _____

_____

Shift positions constantly while sitting or standing? _____

Have a weak grasp? _____

Have one side that seems stronger than the other? _____

What type fo manipulative activies/toys does your child normally enjoy? _____

Play with toys that are age approporiate? _____

Likes puzzles and other manipulative toys? _____

Is (was) your child clumsy in playing with toys? Please explain. _____

_____

Are/were manipulative hand skills difficult for your child? (i.e. use of spoon, cutting, etc.) _____

_____

Social:

Does your child play with siblings and/or children in neighborhood/school: _____

Briefly describe these interactions _____

_____

What are your child's favorite playtime toys and activities? _____

_____

Describe your child's play when involved in these activities _____

_____

How would you describe your child's social skills? _____

_____

Signature _____ **Date** _____

Relationship to the child _____

Practice Policies

Thank you for choosing the Center for Pediatric Therapy for your therapy needs. We are committed to providing high-quality, cost-effective care while meeting your child's needs. Your understanding of our policies are important to our professional relationship. The following are our Practice Policies, which we required you to read and sign prior to treatment. If you have any questions about our fees, policies, or your responsibility – please ask.

Insurance:

Insurance is a contract between you and your insurance company. You are responsible for timely payment of your account and notifying the Center of any changes to your insurance.

The Center for Pediatric Therapy accepts reimbursement for its services by means of assignment of patient's insurance benefits or in currency (cash/check). Copayment, if applicable, deductibles, and co-insurance is payable at each visit. The Center for Pediatric Therapy maintains an office policy to bill your insurance a s a professional courtesy to you. Once the carrier is billed, we will set aside the portion of the balance estimate to be paid by your insurance carrier for 60 days. We require that your estimated portion be paid at the time services are rendered. If your insurance carriers does not remit payment within 60 days, the balance will be due in full from you at that time. We will not become involved in disputed between you and your insurance company regarding deductibles, copayments, or covered charges other than to supply factional information as necessary. The Center for Pediatric Therapy will obtain verification of insurance. Please be advised, an authorization for services does not guarantee payment of services rendered until an actual claim received. If your insurance company will not cover the incurred charges, payment is due upon receipt of the services. If a patient's case must be reviewed by the insurance company to determine if therapy services are covered, and such review takes longer than 60 days, payment will be expected from you prior to the commencement of treatment, or treatment may be postponed until the insurance determination is made.

Cancellation:

____ (Initial) Please sign the "Appointment Cancellation/No Show Policy."

Authorization and Assignment:

____ (Initial) I authorize the release of any and all records to The Houston Spine & Rehabilitation Centers, PLLC or Houston Rehabilitation & Spine Affiliates, PLLC as requested. I authorize payment of any benefits to be paid directly to this facility. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of services rendered, regardless of insurance coverage. I understand if I have an unpaid balance to The Houston Spine & Rehabilitation Centers and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts. I also understand regardless of scheduled future care, any fees for all services will be immediately due and payable. I understand it is my responsibility to consult with my primary care physician to rule out any underlying medical condition not related to musculoskeletal condition, and/or symptoms presented.

Consent for Therapy Evaluation and Treatment:

_____ (Initial) I authorize the Center for Pediatric Therapy to provide appropriate evaluation and treatment as needed. I have reviewed the Practice Policies and understand them.

Patient Name: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____

Privacy Disclosures

Phone:

____ (Initial) I authorize the staff of the Center for Pediatric Therapy to contact me at my home, cell, or any other alternate phone number that I have listed. I prefer (circle one): Home Work Cell

Authorization for US Mail & Email:

Consent for the Center for Pediatric Therapy to mail to my home or email any items that can assist the practice in carrying out TPO, such as appointment reminders, coordination of care, documents requested by myself and patient statements. I understand that with any internet service, there is a risk of sending information through email. All records are kept in our Electronic Medical Record.

_____ (Initial) I acknowledge and consent to receive paper mail.

_____ (Initial) I acknowledge and consent to receive email.

Notice of Privacy Practices:

_____ (Initial) I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certifications.

_____ (Initial) I agree to receive to an electronic copy of the Notice of Privacy Practices (available on our website spineandrehab.com or by contacting the office) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

_____ (Initial) I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

_____ (Initial) I agree for The Houston Spine & Rehabilitation Centers to use and disclose my protected health information (PHI) in the ways described in the Notification and to carry out treatment, payment, and healthcare operations (TPO).

_____ (Initial) I acknowledge I have read or been given the opportunity to read the Notification of Privacy Practices and agree as indicated above.

Protected Health Information:

Due to the privacy laws mentioned above, we are unable to discuss your PHI (including appointment information) with any family member without your expressed consent. If you would like us to be able to discuss any aspect of your PHI with a spouse, parent or other family member please list them below. For minor children we will follow any applicable state or federal laws regarding release of information.

_____ (Initial) I authorize The Center for Pediatric Therapy and all of its healthcare providers to discuss issues regarding my visits, any lab or test results, my appointments or insurance with the following people and understand that this authorization will remain in effect until I notify the office in writing of any changes.

Name of Individual or release information to: _____ Relationship:_____

_____ (Initial) I do not wish to designate anyone to have access to my information.

Patient Name: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____

Houston Spine & Rehabilitation
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APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your child's care to The Center for Pediatric Therapy. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care.

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Effective August 1, 2021, any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $25.00 fee.

- If a patient has two cancelled appointments within a 60-day period, without 24hrs notice, they will lose their scheduled appointment time.

- Any new patient who fails to show for their initial visit will be rescheduled as our schedule allows. This may not be in the same week.

- The cancellation fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office, who may be able to waive the cancelation fee.

You may contact The Center for Pediatric Center 24 hours a day, 7 days a week (281) 292-4800. Should it be after regular business hours, you may leave a message.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____

Date

Houston Center for Pediatric Therapy

PHOTO RELEASE FORM - ADULT

Permission to Use Photograph(s)

MY HEALTHCARE OFFICE: Houston Center for Pediatric Therapy

PATIENT NAME: _____

I hereby consent to the photographing of myself and authorize **MY HEALTHCARE OFFICE** the right to use of these photographs singularly or in conjunction with other photographs for advertising, publicity, commercial, social media or other business purposes printed or digital.

I agree that **MY HEALTHCARE OFFICE** may use such photographs with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, social media and web content.

I release **MY HEALTHCARE OFFICE** from any expectation of confidentiality for myself.

I agree that participation in any publication and website produced by **MY HEALTHCARE OFFICE** confers no right of ownership whatsoever. I release **MY HEALTHCARE OFFICE** and its employees from liability for any claims by myself or any third party in connection with my participation and consent granted through my signing this photo release form.

I HAVE READ AND UNDERSTAND THE ABOVE.

Signature _____ Date _____

PHOTO RELEASE FORM – CHILD(REN)

Permission to Use Photograph(s)

MY HEALTHCARE OFFICE: Houston Center for Pediatric Therapy

PATIENT(S) NAME(S) Please list all minor children below:

Name	Age
_____	_____
_____	_____
_____	_____

I hereby consent to the photographing of the child(ren) listed above and authorize **MY HEALTHCARE OFFICE** the right to use of these photographs singularly or in conjunction with other photographs for advertising, publicity, commercial, social media or other business purposes printed or digital.

I agree that **MY HEALTHCARE OFFICE** may use such photographs with or without my child's name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, social media and web content.

I release **MY HEALTHCARE OFFICE** from any expectation of confidentiality for the child(ren) and attest that I am the parent, legal guardian, or representative of the child(ren) listed above and that I have the authority to authorize **MY HEALTHCARE OFFICE** to use his/her/their photographs.

I agree that participation in any publication and website produced by **MY HEALTHCARE OFFICE** confers no right of ownership whatsoever. I release **MY HEALTHCARE OFFICE** and its employees from liability for any claims by myself or any third party in connection with the participation of the child(ren) listed above.

I HAVE READ AND UNDERSTAND THE ABOVE.

Signature _____ Date _____