ELEVATE
PEDIATRIC THERAPIES
Physical | Occupational | Speech

PATIENT INFORMATION

Date: _____ Patient's Date of Birth: _____ Patient's Gender: _____
Patient's Last Name: _____ First Name: _____ MI: ___
Patient's Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number for Appointment Reminder: _____

RESPONSIBLE PARTY

Name: _____ Relation to Patient: _____
Phone Number: _____ Social Security Number: _____
Address (if different than above): _____
DOB: _____ Email Address: _____
Primary Health Insurance Plan: _____
Policy ID#: _____ Group #: _____
Secondary Health Insurance Plan: _____
Policy ID#: _____ Group #: _____

Below is an explanation of your benefits as provided by your insurance company given the information above. This is not a guarantee of your benefits as it is your responsibility to obtain this information. By signing below you are stating you understand your benefits. Any amount not covered by your insurance will be billed to you as the responsible party.

Deductible _____ Amount Met _____ Co-Pay Due at Time-of-Service _____
Co-Insurance _____ Out-of-Pocket Maximum _____ Amount Met _____
Limitations to Therapy Services _____

PATIENT RELEASE

I hereby authorize Elevate Pediatric Therapies and its agents to furnish all information it may have regarding my condition, treatment and progress while under Elevate's observation or treatment (including the history obtained, physical findings, and prognosis) to the insurance company or its representatives, my employer, the physician on record or my attorney upon their request during treatment and progress conferences. This authorization shall remain valid until revoked by me in writing. Additionally, I authorize payment of medical benefits directly to Elevate Pediatric Therapies for services rendered, and fully accept total responsibility for all services not fully paid for by any insurance company, and/or Medicare/Medicaid as allowed by contractual agreement.

Parent/Guardian Signature: _____ Date: _____
How did you hear about us (circle)
Physician / Family / Friend / Google Search / Social Media / Health Insurance / Other: _____

Patient Name: _____
Patient DOB: _____

Elevate Pediatric Therapies

Clinic Policies

Please review and initial each policy

____ Call the clinic to cancel or reschedule as soon as you know that your child will not be able to attend a scheduled appointment.

____ Excessive cancellations and/or no-shows will result in the loss of regularly scheduled appointments. However, please keep your child home if they have experienced a fever, vomiting, diarrhea, an unexplained rash, or treatment of lice or scabies within the last 24 hours and we can reschedule those cancellations at a later date.

____ Due to insurance liability and out of courtesy for children receiving treatment, no siblings above the age of 1 will be allowed to wait or play in treatment rooms or in the gym.

____ Absolutely NO CELL PHONES in use while in treating areas.

____ During the winter months, when there is a possibility of treacherous travel due to snowy and/or icy roads, we will follow the decision made by Claremore Public Schools. If they cancel school, we will close. If they remain open, we will remain open.

Printed Name: _____ Signature: _____

Date: _____ Relationship to Child: _____

AUTHORIZATION TO REQUEST AND/OR RELEASE INFORMATION

Child's Name: _____ Parent/Legal Guardian: _____

Date of Birth: _____

Does your child receive any therapy services through Sooner Start or a Public School? _____

If YES, please indicate the school district in the RELEASE / RECEIVE INFORMATION sections as we will request an IEP or IFSP for 3rd party payment.

"INFORMATION" is considered but not limited to phone calls, conversations with individuals and copies of records that include medical testing, educational testing, psychological testing, diagnoses and treatment plans and progress.

Please list those people, agencies or medical facilities
that we may RELEASE YOUR CHILD'S INFORMATION TO:

_____

_____

_____

Please list those people, agencies or medical facilities
that we may RECEIVE YOUR CHILD'S INFORMATION FROM:

_____

_____

_____

This authorization expires on this date _____ or when my child is no longer receiving services from Elevate Pediatric Therapies. At any time, you may revoke this authorization. You must indicate your desire to do so in writing and submit to:

Elevate Pediatric Therapies, 1110 W. Will Rogers Blvd, Claremore, OK 74017

I confirm that I have reviewed this authorization form and agree with its statements. My signature below indicates my authorization for the release and receipt of personal health information of the minor child listed above.

Printed Name: _____ Signature: _____

Date: _____ Relationship to Child: _____

NOTICE OF PRIVACY PRACTICES

Elevate Pediatric Therapies, PC

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Elevate Pediatric Therapies is required by law to protect certain aspects of your child's health care information known as Protected Health Information (PHI), and to provide you with this Notice of Privacy Practices.

Uses and Disclosures of PHI: Elevate Pediatric Therapies may use PHI for the following purposes:

1. For Treatment: Elevate may use and disclose your child's PHI to doctors, nurses, technicians, or healthcare professionals caring for you.
2. For Payment: Elevate may use and disclose your child's PHI to obtain reimbursement and determine eligibility.
3. For Healthcare Operations: Elevate may use and disclose your child's PHI for operations such as employee evaluations, licensing, credentialing, and compliance activities.
4. For Emergency Notification: Elevate may use and disclose your PHI to a family member or another person responsible for your care in the event of an emergency.
5. For Law Enforcement Purposes: Elevate may use and disclose your PHI if we suspect your child is a victim of abuse, neglect, or domestic violence. We may also use and disclose your child's PHI for national security, criminal and intelligence activities.
6. For Court Orders and Judicial Matters: Elevate may use and disclose your PHI in response to subpoenas, discovery requests, court or administrative orders, or other legal requests.
7. For Public Health Purposes: Elevate may use and disclose your child's PHI to public health authorities involved in prevention or control of disease, injury, or disability.
8. For Health Oversight Purposes: Elevate may use and disclose your child's PHI to entities providing health oversight, licensing, audits, inspections, and other authorized activities.

Any other use or disclosure of PHI, other than those listed above, will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.

Patient Rights:
1. You have the right to access, copy or inspect your child's PHI.
2. You have the right to amend your child's PHI if errors are found.
3. You have the right to request an accounting of disclosures of your PHI.
4. You have the right to request additional restrictions or disclosures of your PHI.

Questions and Complaints:
If you have any questions regarding this notice, you may speak directly to the clinical director or an available owner of the facility. Please ask for a meeting by phone, or in person if available, or by written request to Elevate Pediatric Therapies, 1110 W. Will Rogers Blvd., Claremore, OK 74017. You may also contact us at 918-341-4343.

Patient Acknowledgement:

I have received Elevate Pediatric Therapies Notice of Privacy Practices, and I have been given the opportunity to review it.

Patient Name (please print): _____ Date: _____
Signature: _____

Parental Consent Form

* **Form must be completed in its entirety or will not be accepted**

Member Name: _____
Member RID #: _____
Member Diagnosis: _____

I (print name of parent/legal guardian)_____
hereby authorize (print name of provider) Elevate Pediatric Therapies _____
to evaluate, as well as provide any subsequent treatment based on the evaluation results for (please check all services that apply) _____ Physical Therapy, _____ Occupational Therapy and/or _____Speech Therapy for child named above.

_____
Signature of Parent/Legal Guardian if a minor

_____
Date Signed by Parent/Legal Guardian

_____
Relationship to Member

_____
Signature of Therapist or Representative of Therapy Group

_____
Date Signed by Provider

ELEVATE PEDIATRIC THERAPIES QUESTIONNAIRE

Child's Name: _____ DOB: _____

Referring Physician: _____

I. REFERRAL INFORMATION

Who referred you to this clinic? _____

What are the general concerns that you have for your child? (Please check all that apply)

☐ Fine Motor ☐ Gross Motor ☐ Sensory Processing ☐ Self-Care Skills

☐ Speech/Language ☐ Social/Emotional ☐ Getting Along With Others

☐ School Performance ☐ Cognition ☐ Behavior ☐ Attention

What are the specific concerns that prompted you or your doctor to seek therapy?

_____

_____

_____

_____

Please list your child's diagnoses (Developmental Delay, Autism, Torticollis, Sensory Processing Disorder, etc.):

_____

_____

_____

II. FAMILY / SOCIAL HISTORY

Please circle any of the below listed problems that may appear in the family history (close relative) of the child:

Intellectual Disability	
Autism	Pervasive Development Disorder
Cerebral Palsy	Seizure
Speech/Language Disorder	Neurologic Problems
Learning Problems	Attention Deficit Disorder
Emotional Problems	Attention Deficit Hyperactivity Disorder

Genetic Syndromes (Please explain): _____
Other: _____

Patient Name: _____
Patient DOB: _____

III. PREGNANCY AND BIRTH HISTORY

1. Birth weight: _____ lbs. _____ oz.
2. Mother's age at the time of pregnancy: _____
   Father's age at the time of pregnancy: _____
3. Number of pregnancies of the child's natural mother: _____
   Number of live births of child's natural mother: _____
   Which pregnancy is this child: _____
4. Prenatal care began: ____ 1st Trimester ____ 2nd Trimester _____ 3rd Trimester
5. Problems during Pregnancy (please choose YES or NO):

Condition	YES	NO
Bleeding/Spotting	☐	☐
Injuries	☐	☐
Diabetic state in pregnancy (sugar in urine)	☐	☐
High Blood Pressure	☐	☐
Infections	☐	☐
Toxic exposure	☐	☐
Preterm labor	☐	☐
Maternal weight gain _____ lbs.	☐	☐

Fetal activity (circle one): Normal Increased Decreased

6. During your pregnancy did your child's mother use? (Circle all that apply)

Substance	Yes	No	If yes, please list / How often
Alcohol	☐	☐	_____
Tobacco	☐	☐	_____
Drugs	☐	☐	_____

7. Length of pregnancy: _____ weeks
8. Labor: spontaneous / induced How long was the labor? _____
9. Delivery: Vaginal / Forceps-Vacuum Assisted / Cesarean
10. Did the baby require oxygen, resuscitation or reviving after birth? ___Yes ___No
    If yes, why and how long? _____
    What were the baby's Apgar scores? _____
11. Did the baby stay in intensive care? ___Yes ___No
    If yes, how long? _____
12. Place of birth: _____ Name of Hospital: _____
13. Discharge from hospital at _____ days of life.

Condition	YES	NO
Problems in the Nursery	☐	☐
Problems breathing	☐	☐
High or low blood sugar	☐	☐
Jaundice (yellow skin)	☐	☐
Bleeding in head	☐	☐
Feeding difficulties	☐	☐

Other: _____

Patient Name: _____
Patient DOB: _____

IV. DEVELOPMENTAL HISTORY – Areas of Development

a. Speech/Language *(talking, understanding, communicating with others)*
Do you think your child is functioning: BELOW AT ABOVE age level? (circle one)
At what age did your child say his/her first word? _____ 2-word phrase _____
What age level does he/she seem to function? _____
Do you have any concerns in this area? _____ Yes _____ No
If yes, what are the concerns? _____

b. Motor Development *(rolling over, sitting, walking, writing, buttoning, cutting)*
Do you think your child is functioning: BELOW AT ABOVE age level? (circle one)
At what age did your child crawl? _____
At what age did your child walk? _____
What age level does he/she seem to function? _____
Do you have any concerns in this area? _____ Yes _____ No
If yes, what are the concerns? _____

c. Cognitive *(problem solving, following instructions, learning in school, intellectual abilities)*
Do you think your child is functioning: BELOW AT ABOVE age level? (circle one)
What age level does he/she seem to function? _____
Do you have any concerns in this area? _____ Yes _____ No
If yes, what are the concerns? _____

d. Social-Emotional *(expressing feelings, needs, getting along with others, attachment, behavior)*
Do you think your child is functioning: BELOW AT ABOVE age level? (circle one)
What age level does he/she seem to function? _____
Do you have any concerns in this area? _____ Yes _____ No
If yes, what are the concerns? _____

e. Areas of Development Milestones *(eating, drinking, dressing, toileting)*
Do you think your child is functioning: BELOW AT ABOVE age level? (circle one)
At what age was your child toilet trained? Day _____ Night _____
At what age was your child pedaling a bike? _____
Tying his/her shoes? _____ Drinking from a cup? _____
Feeding him/herself? _____ Dressing him/herself? _____

f. Educational *(learning to read and write, solve problems)*
Do you think your child is functioning: BELOW AT ABOVE age level? (circle one)
What age level does he/she seem to function? _____
Do you have any concerns in this area? _____ Yes _____ No
If yes, what are the concerns? _____

Patient Name: _____
Patient DOB: _____

V. HEALTH HISTORY (Past Medical History)

Physicians or Specialists involved in your child's care:

_____

_____

Please give details of any medical problems or hospitalizations for your child:

_____

_____

_____

Has your child required any surgeries? ___ Yes ___ No

Please explain:

_____

_____

Has your child had any serious injuries, especially head injuries? ___ Yes ___ No

Please explain:

_____

_____

Is your child currently taking any prescription or non-prescription medications on a regular basis? ___ Yes ___ No

Please list medications:

_____

_____

Does your child have any allergies to foods or medications? ___ Yes ___ No

Please explain:

_____

Diet: Does your child have any particular eating difficulties (gagging, choking on food, coughing during meals, or specific food preferences/taste/texture)?

_____

_____

Is your child on a special diet? ___ Yes ___ No

Does your child use any other special treatments? (herbal supplements, biofeedback, etc.)

_____

Patient Name: _____
Patient DOB: _____

VI. REVIEW OF SYSTEMS

Please check if your child has experienced any of the following:

YES	NO	Condition
☐	☐	Seizures
☐	☐	Staring episodes
☐	☐	Motor or vocal tics
☐	☐	Headaches
☐	☐	Drooling
☐	☐	Ear infections
☐	☐	Chewing/Swallowing difficulties
☐	☐	Cup drinking difficulties
☐	☐	Gagging
☐	☐	Early Childhood Diseases (measles, chicken pox)
☐	☐	Parental concerns about hearing
☐	☐	Aspiration pneumonia
☐	☐	Asthma
☐	☐	Sleep difficulties
☐	☐	Previous MRI or CT Scan
☐	☐	Breathing difficulties
☐	☐	Strabismus
☐	☐	Wears glasses

Previous vision screen/ophthalmologic assessment When: _____
(Please circle one) NORMAL ABNORMAL
Comments: _____

Previous hearing screening/audiological assessment When: _____
(Please circle one) NORMAL ABNORMAL
Comments: _____

VII. SCHOOL INFORMATION

Early Intervention:
Has your child ever received Early Intervention Services? ___ Yes ___ No
(Please circle all that apply): Sooner Start Head Start Preschool Developmental Delay Class

Services received: (Please circle all that apply below)
Speech/Language Cognitive Physical Therapy Occupational Therapy

Child Development Specialist and Nursing / Other: _____

School Attended:
Preschool: _____
Kindergarten: _____
First Grade & up: _____
Is there a current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) in place?
___ Yes ___ No