Horn and Associates in Rehabilitation, PLLC

Parent Questionnaire

Today's Date_____

Identifying Information

Child's Name_____ Date of Birth_____ Sex_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone(s)_____ _____

Email Address(es)_____

Please * preferred method of communication above (home or cell phone, email)

1st Parent/Guardian Name_____Date of Birth_____SSN_____

Address (if different from above)_____

Occupation / Place of Work_____

2nd Parent/Guardian Name_____Date of Birth_____SSN_____

Address (if different from above)_____

Occupation / Place of Work _____

Billing Preference (please circle)

Insurance Private Pay Other_____

Responsible Party_____

Reason for referral / Concerns

_____

_____

Who referred child for services?_____

Physician Name_____

Physician Number and Address_____

Horn and Associates in Rehabilitation, PLLC

Has the child received therapy services in the past?_____

If so, list type of service(s) and length of service(s)_____

Child's school and current grade / daycare_____

Developmental and Medical History

Was the child born full term? _____ If premature, how many weeks?_____

Please describe pregnancy (any infections or illnesses, stress, complications, medications, etc.)

_____

_____

Please describe labor and delivery (vaginal, Cesarean section, induction, complications, length of labor, etc.)

_____

_____

Please describe any significant neonatal issues (NICU stay, need for oxygen and/or fetal monitor, congenital abnormalities, need for surgery, difficulty with feeding, jaundice, colic, etc.)

_____

_____

Please list history of significant illnesses, surgeries, hospitalizations, etc., such as frequent ear infections, strep throat, gastrointestinal issues, seizures, asthma, allergies, need for ear tube placement, tonsillectomy, etc.

_____

_____

Please list any specialists your child has seen, along with when seen and reason for visit.

_____

_____

Has your child had a hearing evaluation? Please list findings_____

Has your child had a vision screening and/or wear glasses?_____

Please list any medications your child takes_____

Please list any diagnoses your child may have received

_____

2412 Greatstone Point
Lexington, Kentucky 40504

(859) 224-4081 (ph.)
(859) 224-4082 (fax)

4127 Todds Road
Lexington, Kentucky 40509

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To the best of your knowledge, at what age did your child:

Roll over_____ Sit Independently_____ Crawl_____

Stand Alone_____ Walk_____ Go Up and Down Stairs_____

Finger Feed_____ Transition to Solid Foods_____ Transition from Bottle to Cup_____

Use Utensils to Feed Self_____ Toilet Train_____ Sleep through the Night_____

Say First Word_____ Put Two Words Together_____ Follow Simple Directions_____

Family and Social History

Please list individuals (with their ages and relationship to child) that live in the same home with the child

_____

_____

Do any family members or those living with child have a history of developmental concerns or delays? If so, please list relationship and concern

_____

_____

What is the primary language spoken in the home?_____

Are the any other languages spoken in the home? If so, please list_____

Does your child have interaction with same-age peers or other children?_____

Does your child interact well with other children?_____

What is your child's favorite activities/toys?_____

Please describe your child's personality and strengths_____

_____

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www.horntherapy.com

Thank you for choosing us for your speech/language, occupational, physical and/or psychological needs. We are committed to providing you with quality and affordable services. Our office policies are outlined below. Please read, ask us any questions and sign in the space provided. A copy will be provided to you upon request.

FINANCIAL POLICY
We are happy to file your insurance but we want you to remember that professional services are rendered and charged to you or the patient and not to the insurance company.

Proof of Insurance: All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license, or a form of government issued photographic identification, as well as current valid proof of insurance. You are responsible to know your benefits. We will collect estimated out of pocket fees on the day of therapy, which includes deductible, copays and/or coinsurance. Our office accepts cash, checks, MasterCard, Visa and Discover Families are responsible for keeping track of the number of visits, or when and what type of authorization/precertification is necessary. The number of visits and payment of all claims is your responsibility, although we do try to track them as well. Please remember that precertification and/or authorization is no guarantee of payment from your insurance company.

Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. We are happy to help you with additional information your insurance company may need to assist in claim payment; however, our office will not enter into a dispute with your insurance company over a claim. If there is no insurance payment activity after 60 days, we will ask for your payment and, of course, reimburse you if your insurance company later pays.

Additional documentation (i.e., disability reports/questionnaires, school updates, school conferences, 504 plans, etc.) and extended phone conversations will be provided based on a time fee and will be the responsibility of the patient.

ATTENDANCE AND CANCELATION POLICY
Consistency in attendance to therapy is essential to making and maintaining progress.

Cancelation/Service Fees: We realize there may be circumstances that require you to cancel your appointment. When these situations occur, **please notify the therapy office at least 24 hour prior to your scheduled appointment**. With this notice, we may be better able to reschedule your therapy time and/or accommodate others waiting for therapy. **Cancelation without 24 hour notice will be assessed a $36.00 cancelation fee**. If you cancel more than one therapy session with different therapists within the same day and without 24 hour notice, this $36.00 fee will be assessed for each session missed. We understand emergencies do arise; in these situations notifications are still expected. Emergency situations will be taken into consideration when assessing the cancellation fee.

Attendance: Regular attendance is expected for therapy. If your attendance falls below 75%, you may lose your regularly scheduled therapy time. If you miss more than 3 sessions without 24 hour notice, you may be discharged from therapy services.

Timeliness: If you arrive late for your session, the session may be cancelled. Many sessions are scheduled for 30 minutes; if you are 10 minutes late to a session, valuable time is lost and we are often unable to accommodate.

Sick Policy: Please respect the health and wellness of all our clients, staff and therapists. We expect you to be fever free and symptom free from illness for at least 24 hours in order to attend therapy sessions.

I understand that I am responsible for any charges not paid by my insurance coverage and I accept responsibility for any collection costs, attorney fees, and any other cost incurred that may result from nonpayment. I understand the above terms and conditions and I authorize my insurance company to pay my claims directly to Horn and Associates in Rehabilitation, PLLC.

_____ _____

Patient or Guardian (if minor) Signature **Date**

_____

Printed Name – Patient or Guardian (if minor)

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Release of Information / Consent to Treatment

_____ Client or Patient's Name

_____ Date of Birth

_____ Parent/Guardian's Name

_____ Patient / Client SS#

_____ Address

_____ City, State, Zip Code

I hereby authorize Horn and Associates in Rehabilitation, PLLC to:
Release: Information and records to Insurance: **YES** _X_ **NO** ____
Release: Information to physicians: **YES** ____ **NO** ____
Physician Name: _____

RELEASE all information and records regarding the above name patient to the following agencies, or persons:
_____

OBTAIN information and records as selected below regarding the above named client or patient from the following agencies or persons:
_____
_____

Please check information to be obtained/disclosed:
_____History and Physical Examination
_____Initial Evaluation
_____Therapy Notes
_____Outpatient Clinic Notes
_____Discharge Summary
_____X-Ray Report

*Initials are required to disclose privileged information
_____Psychological/Psychiatric Records _____*
_____Social Service Records _____*

_____Other (Specify) _____
_____
_____

I, or custodial parent/legal guardian, give permission for **Horn and Associates in Rehabilitation, PLLC,** to administer and interpret assessments and/or testing measurements, and/or initiate therapy, and/or seek emergency medical treatment if required.

CONDITIONS

- The patient or legal parent/guardian agrees to authorize the above named individuals/organization to access her/her confidential health information only for the purpose listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- The patient or legal parent/guardian agrees that any sharing of confidential health information with individuals/organization listed above may be mailed, faxed, electronically sent and/or hand delivered.
- The patient or legal parent/guardian is voluntarily signing this authorization.
- The patient or legal guardian/parent reserves the right to refuse to sign this authorization.
- The patient or legal guardian/parent reserves the right to revoke this authorization at any time. The revocation must be in writing.
- This authorization will be maintained by Horn and Associates in Rehabilitation, PLLC, for a period of twelve (12) months.

Through my execution of this authorization, I represent that I have legal authority to authorize the foregoing and agree to hold Horn and Associates in Rehabilitation, PLLC, harmless and indemnify from and against any and all losses and/or claims they may suffer by reasons of breach of the foregoing representation.

I have read, reviewed and agree with: Horn and Associates in Rehabilitation, PLLC *Notice of Privacy Practices.* A copy of these will be given upon request.

_____ Printed Name

_____ Date

_____ Client or Custodial Parent/Legal Guardian Signature

_____ Witness

Horn and Associates in Rehabilitation, PLLC

Physical Therapy Questionnaire

Today's Date_____

Child's Name_____ Date of Birth_____

Describe the main physical/motor difficulty in which you are seeking services.

_____

Are there any medical/emotional/environmental factors that you believe contribute to the physical/motor difficulty? If yes, please describe.

_____

Has your child been diagnosed with any condition related to the physical/motor difficulty? If so, please list.

_____

Was your child extraordinarily stiff or floppy as a baby? _____

Does your child seem weaker on one side versus the other side? _____

Does your child have any particular places in his/her body that he/she cannot move freely? _____

Does your child have difficulty with any of the following? (please circle):

Head Control	Sitting	Standing	Walking
Rolling	Crawling	Jumping	Holding a Position
Going Up and Down Stairs	Endurance with Activities	Strength	Learning New Movements
Balance	Difficulty Controlling Body	Skipping	Playing on Playground
Throwing/Catching	Riding a Bicycle	Getting In or Out of Positions	

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