HORN AND ASSOCIATES IN REHABILITATION, PLLC

2412 Greatstone Point
Lexington, Kentucky 40504
Phone (859) 224-4081

4127 Todds Road
Lexington, Kentucky 40509
Fax (859) 224-4082

www.horntherapy.com

Parent Questionnaire

Today's date:_____

Identifying Information

Client Name:_____ Date of Birth:_____ Gender:_____

Address:_____

Primary Phone:_____ Relationship:_____

Secondary Phone:_____ Relationship:_____

Email Address(es):_____

Parent/Guardian Name:_____ Date of Birth:_____

Address (if different from above):_____

Occupation/Place of Work:_____

Parent/Guardian Name:_____ Date of Birth:_____

Address (if different from above):_____

Occupation/Place of Work:_____

Billing Preference (please circle):

Insurance Private Pay Other:_____

Responsible Party Name and SSN:_____

Insurance Company / Policy Number:_____

Reason for referral / Concerns

_____

_____

Who referred child for services?_____

Physician Name_____

Physician Number and Address_____

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_____

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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

_____

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_____

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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 interact 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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2024 Consent to Leave Voicemail and/or Email

Client Name:_____Date of Birth:_____

Horn and Associates in Rehabilitation, PLLC, staff may contact you be telephone and/or email you with information such as appointment times, insurance, payment, diagnosis, records, examinations rendered to you, and any other information to your voicemail and/or email with your consent.
By signing this "Consent to Leave Voicemail and/or Email," you consent to Horn and Associates in Rehabilitation, PLLC, staff to leave messages and/or email detailed medical information to the phone number(s) and emails below. This information may include, but not limited to, demographic information, billing information, and medical information.

☐ Phone Number(s):_____
☐ Email Address(es):_____
☐ Do not leave any information on any phone number.
☐ Do not leave any information on any email address.

I understand that Horn and Associates in Rehabilitation, PLLC, cannot require me to sign this consent form in order to receive treatment. I understand that I have the right to revoke this consent at any time. This consent is valid for a period of 12 months unless otherwise revoked. A copy of this form will be provided upon request.

Printed Name:_____
Client or Parent/Legal Guardian Signature:_____Date:_____

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2024 Release of Information / Consent to Treatment

Client Name:_____Date of Birth:_____

I hereby authorize Horn and Associates in Rehabilitation, PLLC, to release any information including the diagnosis, records, evaluation rendered to me, and any other information to establish and maintain good care.

Initials are required to disclose privileged information: _____Psychological Records _____Social Service Records

This information may be released to and from (2-way release):

Insurance: **YES__X___**

Physician: **YES_____NO_____**

Physician Name:_____

Physician Address:_____

Physician Phone Number:_____

List any additional people you choose to have access to this information (e.g., other family members, caregivers, health care professionals, teachers, schools)

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

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 his/her confidential health information only for the purposes 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.

I agree to the supervised participation of health care learners in my care (e.g., resident students, therapy students, graduate students, other clinical students, etc.) I understand my patient records will be held in strict confidentiality and will not be discussed outside the office._____**(Initials)**

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* and *Disclosure Against Surprise Billing*. A copy of these will be given upon request._____**(Initials)**

Printed Name:_____

Client or Custodial Parent/Legal Guardian Signature:_____Date:_____

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2024 OFFICE TERMS AND CONDITIONS

Client Name:_____Date of Birth:_____

Thank you for choosing us for your speech/language, occupational, physical therapy, 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, initial, and sign in the space provided. A copy will be provided to you upon request.

FINANCIAL POLICY

We are happy to send claims to insurance but please keep in mind professional services are rendered and charged to you or the patient and not to the insurance company. If our services are out of network for your insurance, we will be glad to provide you with documentation so you can send claims to your insurance company if you choose.

All patients must complete paperwork and consent forms before seeing the provider. We must obtain a copy of your driver's license/government-issued photographic identification and current valid proof of insurance. **Our office does a courtesy benefit check before your first appointment and at the beginning of the year. A member of the front office will send the primary email address on file your benefit information and estimated out-of-pocket cost. You are responsible for knowing your benefits.** 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. _____**(Initials)**

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. _____**(Initials)**

Patient responsibility payments (copays, deductibles, coinsurance, and all outstanding balances) are due at the time of service. Our office accepts cash, checks, MasterCard, Visa, and Discover. Our preference is to have a credit card on file, which will be charged at time of billing, typically within 24-48 hours of the visit. If payments have not been made for more than 2 consecutive weeks, without arrangements made with office staff, services may be put on hold until payments are settled. _____**(Initials)**

It is your responsibility to notify our office immediately of any changes in your insurance. Failure to do so may result in your claims being denied and becoming patient responsibility. _____(Initials)

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-based fee and will be the responsibility of the patient. _____**(Initials)**

ATTENDANCE POLICY

Consistency in attendance to therapy is essential to making and maintaining progress.

Attendance: Regular attendance is expected for therapy. If 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. _____**(Initials)**

Timeliness: If you arrive late for your session, the session may be canceled. 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. Arriving more than 10 minutes late to a session without prior notification may qualify as a no-show. _____**(Initials)**

Missed Visit Fee: We realize there may be circumstances that require you to cancel your appointment. When these situations occur, please notify the office at least 24 hours 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

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without 24-hour notice will be assessed a $48.00 cancellation fee. If you cancel more than one therapy session with different therapists within the same day and without 24-hour notice, this $48.00 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 cancelation fee. Messages may be left after hours through our voicemail system or email. _____**(Initials)**

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 to attend therapy sessions. If you have any of the following symptoms, please notify our office immediately: fever, cough, excessive fatigue, or flu-like symptoms.
_____**(Initials)**

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 and agree to the above terms and conditions. I authorize my insurance company to pay my claims directly to Horn and Associates in Rehabilitation, PLLC.

_____
Printed Name of Client or Parent/Guardian

_____ _____
Client or Parent/Guardian Signature Date

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2024 Consent to Treat using Telehealth

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that there are potential risks involving technology, including but not limited to: Internet interruptions and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my username and password and not sharing these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if it is felt that this type of service delivery does not benefit my needs.

I have read and understand the information provided above regarding telehealth or teletherapy, have discussed it with my health care provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth or teletherapy in my care.

Client Name: _____ Date of Birth: _____

Email Address: _____

Emergency Contact (Name and Phone Number): _____

Client or Parent/Guardian Printed Name: _____

Client or Parent/Guardian Signature: _____ Date: _____

Horn and Associates in Rehabilitation, PLLC

SENSORIMOTOR HISTORY

Child's Name: _____DOB: _____Date: _____

Please think of the various stages of your child's development, considering behavior which comes to mind as you answer these questions. What do you think of as being different from other children you know? Were there times when his/her behavior was difficult to cope with in the family unit?

The following questions are posed to help in compiling a more complete picture of your child from early infancy to present developmental stage. Check the choice which applies: Yes, No, Used To, or N/A (not old enough yet, or for other reasons, non-applicable). Add narrative information on the last page of this form if needed. Thank you for your cooperation.

I. TASTE AND SMELL

Does child:

	YES	NO	USED TO	N/A
1. Act as though all foods taste the same	___	___	___	___
2. Avoid or crave certain foods	___	___	___	___
3. Chew on non-food items	___	___	___	___
4. Have any feeding problems	___	___	___	___
5. Have trouble with textured foods	___	___	___	___
6. Have sensitivity to any unusual smells	___	___	___	___
7. Taste or smell toys, clothes, etc. more than usual	___	___	___	___

II. AUDITORY

Does child:

	YES	NO	USED TO	N/A
1. Have a diagnosed hearing problem	___	___	___	___
2. Have tubes in ears	___	___	___	___
3. Have frequent ear infections	___	___	___	___
4. Seem too sensitive to sound	___	___	___	___
5. Respond negatively to unexpected sounds	___	___	___	___
6. Have fears of any particular sounds Describe:_____	___	___	___	___
7. Become distracted by sounds such as refrigerator, fans, fluorescent light bulbs, heaters, etc.	___	___	___	___
8. Miss some sounds or words	___	___	___	___
9. Fail to listen or pay attention to what is said	___	___	___	___

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AUDITORY CONT'D.	YES	NO	USED TO	N/A
10. Seem to be confused about what direction sounds come from	___	___	___	___
11. Like to make loud noises	___	___	___	___
12. Like to sing and/or dance to music	___	___	___	___
13. Have difficulty copying rhythmic sounds	___	___	___	___
14. Fail to follow through to act upon requests to do something (to understand directions)	___	___	___	___
15. Have difficulty when 2 or 3 steps of instructions are given at once	___	___	___	___
16. Talk excessively	___	___	___	___
17. Have difficulty listening due to excessive talking	___	___	___	___
18. Have a delay in speech development	___	___	___	___

III. TACTILE

Does child:	YES	NO	USED TO	N/A
1. Like to be touched	___	___	___	___
2. Dislike being held or cuddled	___	___	___	___
3. Prefer to touch rather than be touched	___	___	___	___
4. Seem excessively ticklish	___	___	___	___
5. Seem easily irritated/enraged when touched by siblings/playmates	___	___	___	___
6. Have a strong need to touch objects and people	___	___	___	___
7. Seem to pick fights	___	___	___	___
8. Pinch, bite, or otherwise hurt self or others	___	___	___	___
9. Frequently bump or push others	___	___	___	___
10. Bang head on purpose	___	___	___	___
11. Like to touch animals	___	___	___	___
12. Dislike the feeling of certain clothing	___	___	___	___
13. Over/under dress for the temperature	___	___	___	___
14. Overheat easily	___	___	___	___
15. Seem overly sensitive to food/water temperature	___	___	___	___
16. Seem overly sensitive to rough food textures	___	___	___	___

TACTILE CONT'D.	YES	NO	USED TO	N/A
17. Prefer bath over showers if choice is available	___	___	___	___
18. Like to play in water, mud, sand, clay, etc.	___	___	___	___
19. Seem to lack normal awareness of being touched	___	___	___	___
20. Often seem unaware of cuts and bruises	___	___	___	___
21. Avoid using hands	___	___	___	___
22. Examine objects or clothes with hands	___	___	___	___
23. Mouth/chew on objects or clothes excessively	___	___	___	___
24. Walk on toes	___	___	___	___
25. Dislike haircuts	___	___	___	___
26. Dislike nails trimmed	___	___	___	___

IV. VESTIBULAR

Does child:	YES	NO	USED TO	N/A
1. Arch back when held or moved	___	___	___	___
2. Enjoy being rocked	___	___	___	___
3. Like being tossed in the air	___	___	___	___
4. Like fast spinning carnival rides	___	___	___	___
5. Like to swing	___	___	___	___
6. Spin or whirl more than other children	___	___	___	___
7. Become carsick easily	___	___	___	___
8. Become nauseous and/or vomit from movement experiences	___	___	___	___
9. Rock while sitting	___	___	___	___
10. Jump a lot	___	___	___	___
11. Have fear in space (stairs, heights)	___	___	___	___
12. Lose balance easily	___	___	___	___
13. Misunderstand meaning of words used in relation to movement and/or position	___	___	___	___

V. VISUAL

Does or is child:	YES	NO	USED TO	N/A
1. Have a diagnosed visual problem	___	___	___	___
2. Seem very sensitive to light	___	___	___	___
3. Have trouble following with eyes	___	___	___	___
4. Avoid eye contact	___	___	___	___
5. Become distracted by visual stimuli	___	___	___	___
6. Dislike having eyes covered	___	___	___	___
7. Able to close eyes for short periods of time	___	___	___	___
8. Make reversals when copying and reading	___	___	___	___
9. Like playing in the dark	___	___	___	___
10. Have trouble discriminating shapes or colors	___	___	___	___
11. Squint often	___	___	___	___
12. Able to look at something far away	___	___	___	___
13. Able to look at something close	___	___	___	___

VI. MUSCLE TONE

Does child:	YES	NO	USED TO	N/A
1. Feel heavier than he/she looks	___	___	___	___
2. Have good endurance	___	___	___	___
3. Have any diagnosed muscle problem	___	___	___	___
4. Have flat feet	___	___	___	___
5. Slump when sitting	___	___	___	___
6. Tire easily	___	___	___	___
7. Seem generally weak	___	___	___	___
8. Keep mouth open	___	___	___	___
9. Prefer to lie on back vs. stomach	___	___	___	___

VII. COORDINATION

Does or did child:	YES	NO	USED TO	N/A
1. Sit, stand, or walk late	___	___	___	___
2. Sit, stand, or walk early	___	___	___	___
3. Creep/crawl unusually long	___	___	___	___
4. Creep/crawl for brief period	___	___	___	___
5. Creep on tummy or bottom	___	___	___	___
6. Trip or fall a lot	___	___	___	___
7. Have slow, deliberate movements	___	___	___	___

COORDINATION CONT'D.	YES	NO	USED TO	N/A
8. Play with toys appropriately for age	___	___	___	___
9. Have difficulty with sequential tasks (dressing, buttoning, shoe tying)	___	___	___	___
10. Seem clumsy playing with toys	___	___	___	___
11. Have difficulty learning to hold a pencil or crayon in 3-point position	___	___	___	___
12. Have awkward or clumsy movements	___	___	___	___
13. Bump into things when moving	___	___	___	___
14. Demonstrate a dominate hand	___	___	___	___
15. Have poor handwriting	___	___	___	___
16. Handle small things easily	___	___	___	___
17. Eat neatly for age	___	___	___	___
18. Have rigid movements	___	___	___	___
19. Grimace during fine motor tasks	___	___	___	___
20. Have shaky hands during fine motor tasks	___	___	___	___
21. Enjoy sports, gym, etc.	___	___	___	___

VIII. BEHAVIOR/TEMPERAMENT

Is or does child:	YES	NO	USED TO	N/A
1. Quiet, calm, relaxed, patient	___	___	___	___
2. Active, outgoing, enthusiastic	___	___	___	___
3. Intense, easily frustrated, anxious	___	___	___	___
4. Explosive	___	___	___	___
5. Hyperactive, always in perpetual motion	___	___	___	___
6. In the same mood all day as when he/she wakes	___	___	___	___
7. An early riser, immediately on the go	___	___	___	___
8. Clingy	___	___	___	___
9. Predictable	___	___	___	___
10. Rigid, set in ways	___	___	___	___
11. Adaptable, flexible	___	___	___	___
12. Have regular sleep patterns	___	___	___	___
13. Have difficulty falling asleep	___	___	___	___
14. Sleep in own bed	___	___	___	___
15. Wake frequently	___	___	___	___
16. Scream when wakes at night	___	___	___	___
17. Able to play alone for a reasonable length	___	___	___	___
18. Destructive with toys	___	___	___	___

BEHAVIOR/TEMPERAMENT CONT'D.	YES	NO	USED TO	N/A
19. Have a short attention span	___	___	___	___
20. Distractible	___	___	___	___
21. Have difficulty making a choice	___	___	___	___
22. Demonstrate self stimulating behaviors	___	___	___	___
23. Have frequent tantrums	___	___	___	___
24. Display extreme mood changes	___	___	___	___
25. Unable to adjust to routine change	___	___	___	___
26. Have aggressive, acting out behaviors	___	___	___	___
27. Make friends easily	___	___	___	___
28. Prefer the company of adults or older children	___	___	___	___
29. Prefer playing with children 1-2 years younger	___	___	___	___
30. Interact with anyone, including strangers	___	___	___	___
31. Seem to be a loner	___	___	___	___
32. Need control of the environment or activity	___	___	___	___
33. Have trouble responding to limit settings	___	___	___	___
34. Express feelings of low self-esteem	___	___	___	___
35. Express feelings of failure and frustration	___	___	___	___
36. Seem discouraged or depressed	___	___	___	___

IX. LEARNING STYLES (SCHOOL AGED CHILDREN)

Does child:	YES	NO	USED TO	N/A
1. Recognize own errors	___	___	___	___
2. Learn from mistakes	___	___	___	___
3. Acquire materials needed for a task	___	___	___	___
4. Able to set up a work space	___	___	___	___
5. Maintain work space	___	___	___	___
6. Able to work independently	___	___	___	___
7. Generalize known skills to acquire new skills	___	___	___	___
8. Demonstrate age appropriate memory	___	___	___	___

LEARNING STYLES CONT'D.	YES	NO	USED TO	N/A
9. Ask for help appropriately	___	___	___	___
10. Plan ahead	___	___	___	___
11. Create new ideas and ways of doing things	___	___	___	___
12. Use age appropriate content in written language	___	___	___	___
13. Complete work on time	___	___	___	___
14. Have average reading level	___	___	___	___
15. Have average math level	___	___	___	___
16. Current placement/services in school_____				

X. SELF-HELP ABILITIES

	YES	NO	SOMETIMES
1. Can child take off simple clothing?			
Shirt	___	___	___
Pants	___	___	___
Socks	___	___	___
Shoes	___	___	___
Undergarments	___	___	___
2. Can child put on simple clothing?			
Shirt	___	___	___
Pants	___	___	___
Socks	___	___	___
Shoes	___	___	___
Undergarments	___	___	___
3. Can child manipulate the following?			
Zippers	___	___	___
Snaps	___	___	___
Velcro	___	___	___
Buttons	___	___	___
Buckles	___	___	___
Shoelaces	___	___	___
4. Does child use the following without help?			
Spoon	___	___	___
Fork	___	___	___
Knife	___	___	___
Bottle	___	___	___
Open cup	___	___	___
Sipper cup/ adaptive cup	___	___	___
Straw	___	___	___
Toothbrush	___	___	___

SELF-HELP ABILITIES CONT.

5. Does child have any difficulties chewing or drinking? _____

Describe_____

_____

6. Is child toilet trained? _____If no, does the child alert an adult if diaper/pull-up needs changing? _____If yes, does the child alert an adult before using the bathroom? _____

COMMENTS AND CONCERNS

_____

_____

_____

_____

_____

_____

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_____

_____

_____

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