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____

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

____

Horn and Associates in Rehabilitation, PLLC

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____

____

HORN AND ASSOCIATES IN REHABILITATION, PLLC

2412 Greatstone Point
Lexington, Kentucky 40504

4127 Todds Road
Lexington, KY 40509

Phone (859) 224-4081 Fax (859) 224-4082
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

Speech and Language Therapy Questionnaire

Today's Date_______________

Child's Name____ Date of Birth________________

Describe the main speech/language difficulty in which you are seeking services.

____

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

____

How does the child communicate (eye gaze, facial expressions, gestures, signs, augmentative communication system, vocalizations, simple words, phrases, sentences)?

____

How does the speech/language difficulty affect the child's behavior and ability to participate in daily activities?

____

Are there hearing concerns with the child? If so, please describe and indicate if a hearing test has been completed.

____

Feeding Concerns

Are there feeding concerns with the child? If so, please describe.

____

Please describe your child's abilities to transition from a bottle to a cup, transition to purees, and transition to table foods.

____

____

Is your child able to take food from a spoon/utensil? Finger feed? Feed self with utensils? Drink from an open cup? Drink from a straw?

____

Is drooling an issue with your child? If so, please describe. ____

Does your child take a pacifier? Suck on fingers? Bite nails?____

What are your child's preferred foods and textures? What textures/foods does your child refuse? Is gagging or vomiting present when trying non-preferred foods?

____
____

Describe any medical concerns with feeding, including history of reflux, allergies, GI issues, etc.

____
____
____
____

Academic Concerns

Are there academic concerns with the child? If so, please describe.

____
____
____
____

Please your child's educational history (i.e., schools attended, special services provided at school, etc.).

____
____
____

Does your child have difficulty following multiple step directions, remembering facts or details of stories, understanding the main idea of a story, or retelling a story?

____

What is your child's learning style? What are your child's strengths and weaknesses with learning?

____
____