



# HORN AND ASSOCIATES IN REHABILITATION, PLLC

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

[www.horntherapy.com](http://www.horntherapy.com)

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

## 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

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

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What is the primary language spoken in the home? \_\_\_\_\_

Are there any other languages spoken in the home? If so, please list \_\_\_\_\_

Does your child interact with same-age peers or other children?

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Does your child interact well with other children?

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What is your child's favorite activities/toys?

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Please describe your child's personality and strengths

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### Physical Therapy Questionnaire

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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### 2024 Consent to Leave Voicemail and/or Email

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Horn and Associates in Rehabilitation, PLLC, staff may contact you by 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. Cancellation



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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: \_\_\_\_\_