12012 E. Mission Ave.
Spokane Valley, WA 99206
Phone:(509) 413-1630
Fax:(509) 413-1673
www.synergyspokane.com

6270 N. Government Way
Dalton Gardens, ID 83815
Phone:(208) 666-0611
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Pediatric Patient Information

Patient name: _____ Date: _____

Date of Birth: _____ Age:_____ ☐ Female ☐ Male

Parental Status: ☐Biological ☐Adoptive ☐Foster ☐Legal Guardian

Parent/Guardian: _____ _____ Contact:_____ _____
Name DOB Primary# Secondary#

:_____ _____ Contact:_____ _____
Name DOB Primary# Secondary#

E-mail Address: _____ _____

With whom does the child reside?_____

Siblings' names and ages:_____

Address: _____
Street Apt# City State Zip

Person Responsible for Account – please check one: □ Guardian □ Father □ Mother

Emergency Contact	How did you hear about us?
_____ _____ Name Phone# _____ _____ Name Phone# I authorize Synergy to also discuss this account with the following people: _____ _____	□ Friend/Family: _____ □ I'm a returning patient □ Website □ Internet Search □ Phonebook □ Drive by □ Physician □ Insurance company: _____

Insurance Information

Primary Insurance	Secondary Insurance
_____ (Subscriber) Last First MI _____ Birth date (mo/day/year) Relationship to Patient _____ Employer Insurance Co. & Phone # _____ SS# Subscriber # Group #	_____ (Subscriber) Last First MI _____ Birth date (mo/day/year) Relationship to Patient _____ Employer Insurance Co. & Phone # _____ SS# Subscriber # Group #

*Patients with Idaho Medicaid must have prior authorization to receive occupational therapy after the $1,800 allowable in any calendar year. Synergy Healthcare will track visits to obtain prior authorization in a timely manner if needed. However, it is your responsibility to notify us of any occupational therapy evaluation or treatment received at other facilities. Failure to do so will cause a gap in authorized services and denial of insurance claims by Medicare.

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Patient Agreements

As the parent/legal guardian of _____, I authorize his/her therapy evaluation and treatment.

I understand Synergy Healthcare does their best to work within the confines of my insurance plan, however I am responsible for keeping track of the details of my specific insurance plan including: required referrals or prescriptions, insurance authorizations, benefit limits, co-pays, coinsurance and deductibles.

I authorize my/my child's insurance company to make payments directly to Synergy Healthcare Inc.

I grant release of medical history and other information about treatment to third party payers and other health professionals.

I understand that if the insurance does not cover the billed amount, I am responsible for the unpaid balance. I understand that if I have an unpaid balance with Synergy Healthcare a minimum monthly finance charge will be applied of $2.00 up to 1% of my end of the month balance. In case of default payment I am responsible for any legal interest, collection costs and reasonable attorney's fees. There is a $25.00 return check fee on all unpaid checks to Synergy Healthcare.

The information on the patient information page and medical history is correct to the best of my knowledge.
I request and consent to receive treatment at Synergy Healthcare Inc.

I understand that my health is important and will take necessary steps to improve it under the guidance of Synergy Healthcare's highly trained therapists.

Patient/Guardian _____ _____

Signature **Date**

Notice of Privacy Practices Acknowledgement:

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that Synergy Healthcare's *Notice of Privacy Practices* has been made available to me, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Guardian _____ _____

Signature **Date**

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Appointment Policy:

Timeliness: Please arrive at least five minutes early to scheduled appointment. If you are late to your appointments, a different time may be offered if available. Your appointment may be shortened, or you may lose out on the opportunity to partake in your therapy session that day.

Parent and Sibling: Parents are required to stay on site during therapy sessions, and are encouraged to observe and participate in their child's therapy session. Time will be allowed within the sessions for you and the therapist to discuss home program recommendations and your child's progress. Siblings are the responsibility and under supervision of parents, however if appropriate, we try to encourage involvement in therapy sessions for the benefit of your family. Siblings must stay in the same area as parents and treated sibling. It is required they ask the therapist's permission before using any equipment, games, supplies, or activities.

Cancellation and No-Show: Synergy Healthcare requires 24 hours notice prior to cancelling your appointment. If you do not comply with this policy or no-show for your appointment you are at risk of being discharged for a period of time.

When you don't show as scheduled, three people are hurt: 1) Your child, because they don't get the treatment they need as prescribed by the doctor and/or OT. 2) The therapist who now has space in their schedule because the time was reserved for you personally; and 3) Another patient who could have been scheduled for treatment if you had given proper notice.
Three no shows or 3 consecutive cancelled sessions will result in immediate discharge from the program. Discharge due to absence will be reported to your physician.

Illness: Your therapist works in close contact with many people, including medically fragile children that become ill very easily. Please be respectful and cancel your child's appointment if your child (or anyone that will attend the appointment with him or her) is ill. You should cancel your child's appointment if he or she has any of the following: Vomiting, Fever over 100 degrees, Lice, Diarrhea, Red or runny eyes, Chickenpox, Rash, Cough or nasal drainage, Antibiotic therapy - first 24 hours.
Therapist Cancellations: Synergy Healthcare will notify you as soon as possible if we must cancel your appointment due to therapist illness or unsafe weather conditions for home visits.

Behavior Policy:

At Synergy Healthcare the safety of our therapist and your family is our priority. We implement a firm behavioral policy for any type of verbal or physical aggression or abuse at our office, which may place our therapist, staff or other families at risk. We reserve the right to protect the safety of all clients at our office and our professionals that work at Synergy Healthcare.

If an incident of verbal or physical aggression from a client or caregiver occurs towards our staff or other families present in our office, the aggressor may be asked to leave and seek services elsewhere. If an incident occurs at the office and with the therapist's discretion you are not asked to leave, our therapist's will develop a behavior plan of action with your family in lieu of how to proceed if the behavior happens again. It is up to the therapist's discretion if they feel calling 911 is needed to protect the safety of themselves, the family, or other clients in the office.

We are requiring parents and/or caregivers to be present during all therapy sessions. When a parent or caregiver is present, we can provide more information for progress toward therapy goals, teach home strategies, as well as reduce liability for any party in an incident were to happen in your absence.

Synergy Healthcare staff will do our best to make an effort to plan with your family to assist in decreasing behaviors, however it is up to the therapist's discretion for the safety of staff and other families at our office whether or not the client/family in question will be able to continue to seek services with Synergy Healthcare.

Furthermore, if your child is not toilet trained, we ask that you remain on the premises in case that diapering is needed during the session and for the comfort of your child. Diapering is not the responsibility of the therapist working with your family unless it has been addressed as a therapy goal that the therapist has set up for your child.

I have read, understand, and agree to the above listed policies.
Patient/Guardian Signature_____ **Date** _____

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History

Prenatal History

□Foster or adoptive parent with limited knowledge of birth history

Please indicate if any of the following occurred during the mother's pregnancy:

		Please Describe
Infections	☐ Yes ☐ No	_____
Illnesses	☐ Yes ☐ No	_____
Medications	☐ Yes ☐ No	_____
Drug Exposure	☐ Yes ☐ No	_____
Alcoholic Exposure	☐ Yes ☐ No	_____
Other Complications	☐ Yes ☐ No	_____

Birth History

Birth Order ☐ Single ☐ Twin A ☐ Twin B ☐ Multiple #____

Delivery
Birth Weight Pounds _____ Ounces _____
☐ Full-Term ☐ Premature Number of weeks_____
☐ Vaginal ☐ Planned C-Section ☐ Emergency C-Section
☐ Unassisted ☐ Assisted by Forceps ☐ Assisted by suction

Complications
☐ Breech ☐ Multiple Births ☐ Nuchal Cord
☐ Premature Rupture of Membranes ☐ Meconium Aspiration ☐ Fetal Distress
☐Other:_____

Hospitalization ☐ Regular Nursery ☐ Special Care Nursery ☐ NICU
Length of hospital stay?_____
Additional information_____

Medical History

		Please Describe (date and frequency if applicable)
Immunization Current	□Yes □No	_____
Hospitalizations	□Yes □No	_____
Surgeries	□Yes □No	_____
Seizures	□Yes □No	_____
Heart problems	□Yes □No	_____
Breathing difficulties	□Yes □No	_____
Allergies	□Yes □No	_____
Nutritional concerns	□Yes □No	_____
Feeding Difficulties	□Yes □No	_____
Reflux	□Yes □No	_____
Ports, Tubes, or Shunts	□Yes □No	_____
Casts or braces	□Yes □No	_____
Skin breakdown	□Yes □No	_____
Ear infections	□Yes □No	_____
Pain issues	□Yes □No	_____
Vision concerns	□Yes □No	_____
Any previous infections	☐Yes ☐No	_____

If yes, how often, do they persist, is it sudden or gradual onset. _____

Hearing concerns	□Yes □No	_____
Current medications		_____
Special Diets		_____

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History Continued

Does your child have a current diagnosis? □Yes □No
If yes please state_____

Who is your referring physician?
_____

Any specialists your child is currently being followed by? □Yes □No
If yes state what for. _____

Education and Therapy History

Has your child received early intervention service or any previous therapies in the past? □Yes □No
If yes, which type and how often?
□ Physical Therapy _____ ☐ Occupation Therapy _____
☐ Speech Therapy _____ ☐ Developmental Therapy _____

Is your child currently enrolled in school? □Yes □No
Name of School _____ Grade Level_____

Does your child receive therapies as part of an IEP at school? □Yes □No
If yes, which type and how often?
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Please bring a copy of your child's most recent IEP with you to your first visit.

Does your child receive behavioral therapy services? □Yes □No Name of Agency _____

Does your child currently participate in other outpatient therapies? □Yes □No If yes, which type and how often?
□ Physical Therapy _____ ☐ Occupation Therapy _____
☐ Speech Therapy _____ ☐ Psychological Therapy _____

Does your child have any behavioral concerns? If yes, what methods are you currently using?
_____

_____

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Developmental History

At approximately what age did your child begin to do the following without help?

Roll Over	_____	Eat Table Food	_____	Drink From Cup	_____
Sit	_____	Crawl	_____	Feed Self w/Utensils	_____
Walk	_____	Say First Word	_____	Say Sentences	_____
Run	_____	Jump	_____	Ride Bike	_____

Other concerns in this area:_____

How does your child sleep? ☐Good ☐Fair ☐Poor
Any concerns with sleep?_____

How does your child eat? ☐Good ☐Fair ☐Poor
Infant Feeding ☐Breast ☐Bottle ☐Baby Food ☐Table Food
Any concerns with feeding? _____

Does your child take a multivitamin or supplements □Yes □No
Please list Vitamins/supplements:_____

Language Development

Age when child: Spoke first word_____ Combined words_____ Spoke in sentences_____

What was your child's first word(s)?_____First sentence_____

Which sounds (if any) are incorrect?_____

How many words can your child say (list if fewer than 15)?_____

_____

Does your child have difficulty with understanding you? □Yes □No

Does your child have difficulty following directions? □Yes □No

Any speech or hearing problems in the immediate or extended family (explain)?_____

_____

Social Development

Other adults living in the home:_____

Moves prior to age 10:_____

Relationship with peers:_____

Activities shared with parents and siblings:_____

How does your child handle frustration:_____

Conflict:_____ Separation:_____

Regular responsibilities:_____

Favorite: place_____ people:_____ toys:_____

Snacks:_____ activities:_____ TV:_____

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What motivates your child the most?_____

_____

What are your child's strengths? _____

_____

What are your child's weaknesses? _____

_____

Additional Information

Do you have religious, dietary, or cultural needs that you would like for us to be aware of? _____

_____

We want every child to receive optimal benefit from his or her therapy. Please let us know if there are days or times that work well, or that do not work at all, for your child to schedule therapy. We will make every effort to accommodate your requests as our schedule permits.

_____

_____

_____ _____

Parent/ Guardian Signature Date

_____ _____

Therapist Signature Date