TIDELANDS HEALTH
PEDIATRIC REHABILITATION SERVICES

PEDIATRIC MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name:__________________________ Date: ____/____/____ Birthdate: ___/____/____ Age: _____

Height: ________ Weight: ________ Referring Physician:___________________________

Medical History: *(Please check yes/no)*

___ Diabetes ___ Cancer ___ Tuberculosis ___ Visual Impaired
___ Epilepsy ___ HIV / AIDS ___ Hearing Impaired ___ Asthma ___ MRSA
___ Latex Allergy ___ Scoliosis ___ Hepatitis ___ Allergies

___ Food Allergies. Please list:____

Please list any medications that your child is taking:____

____

Please list any diagnostic tests that have been performed for this condition:________________________

____

Has surgery been performed for the condition? Y or N If yes, please give approximate date:____________

What are the current symptoms?____

When did the injury or symptoms occur?____

Does your child have pain? If so, where is the pain or problem located?___________________________

How does your child let you know he/she has pain?____

Please rate your child's pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine) __________

Have you recently experienced abuse or neglect (physical, emotional, etc.)? Y or N

Do you plan to harm yourself or commit suicide? Y or N (Lifeline number given to caretaker ____ Therapist's initials)

Has your child received a speech therapy evaluation before? Y or N

Is your child being seen by any Home Health Services or Agencies? Y or N

If so, please list:____

What do you hope to accomplish with therapy?____

____

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Tidelands Health Pediatric Rehabilitation.

Parent/Guardian Signature:_________________________________

Therapist's Comments:____

____

Therapist Signature:________________________________ Date/Time:_______________________

TIDELANDS HEALTH
REHABILITATION SERVICES

Welcome to **TIDELANDS HEALTH REHABILITATION** (A part of Georgetown Memorial Hospital). Our therapists are dedicated to providing you with the maximum benefits of rehabilitation therapy. The goal of all therapies provided is to help each patient achieve their highest level of ability through any available treatments. The following are guidelines that we hope you will follow for you to receive maximum benefit through your plan of care.

- During your initial visit, you and your therapist will establish treatment goals to be achieved during your rehabilitation.
- Consistent attendance for all scheduled rehabilitation appointments is required.
- You may receive an appointment reminder by text message. Based on your cell phone plan standard text messaging rates may apply. You are able to opt out of this service at any time.

Personal Cell # ______________________ ◻ Smart phone
◻ Not a smart phone

- **PLEASE be on time.** If you are 15 minutes late, we may have to reschedule your appointment. Please call ahead if you know that you will be late. We might be able to schedule you for a different time in the same day.
- If you need to cancel an appointment, please do so **at least 24 hours** in advance.
- If you do **not show** for **3 appts**., you may be **discharged** from therapy services and your physician will be notified.
- Your therapist will instruct you in a home exercise program. It is important that you follow the instructions given to you to receive maximum benefit from your therapy.
- We will send periodic updates or progress notes to your physician.
- You may be asked to provide your full name and date of birth to confirm your identity to the staff member escorting you to your treatment.

The goal of our staff is to provide excellent service and care for each patient on an individual basis. We will assist you in every way to achieve a positive outcome.

Patient Name (Print): ______________________________________

Patient/Guardian Signature: _________________________________ Date: ____________

Witness: ____ Date: ____________

Patient Payment Responsibility Form

As a courtesy to our patient's, Tidelands Health Rehabilitation Services will be contacting your insurance provider to determine outpatient rehabilitation coverage information.

- Patient will be provided a copy of their insurance benefit information prior to starting their first visit of rehabilitation service. The coverage determination does not guarantee payment by your insurance plan.

- Patient will be responsible for any additional payments not covered by their insurance provider. This includes all applicable premiums, deductibles, and / or co-payment for each visit

- Patient is responsible for knowledge of their insurance coverage for outpatient hospital based physical therapy, occupational therapy, and / or speech therapy services.

- According to your insurance provider you are:

  ______________ eligible for outpatient rehabilitation benefits at this time

  ______________ not eligible for outpatient rehabilitation benefits at this time

- A patient may qualify for available discounts. Please ask the receptionist for more information.

- Medicare covers hospital based outpatient rehabilitation at 80%

<u>Common Insurance Terms</u>

Deductible: A set amount of money you will pay before the insurance coverage starts paying for services

Coinsurance: After the deducible is met this will be your share of the costs. It is usually configured into a percentage

Copay: A fixed amount you pay at the time of a particular type of service

Allowable: Maximum amount the insurance company will pay for a specific service. If the provider charges more than the allowed amount you may have to pay the difference. A preferred provider many not balance bill you.

<u>Agreement</u>

I agree to assist with tracking my insurance coverage allowed by my insurance company. If there is a discrepancy in coverage, I will alert a representative of Tidelands Health Rehabilitation Services immediately.

Please sign below to acknowledge and agree with the information provided above.

Patient/Guardian Signature: ______________________________________ Date: ________________

Witness: ____ Date: ________________

Patient Name: ________________________

DOB: ______________________________

TIDELANDS HEALTH

PEDIATRIC REHABILITATION SERVICES

Thank you for choosing to be a part of the Tidelands Health family. Our therapists are dedicated to providing you and your child with the best services available. The goal of physical, occupational, and speech therapy is to promote function, educate families, and help integrate your child into the community. Parent participation and education is crucial for your child to progress in therapy. Providing a safe, clean, and calm environment is also important. Below are guidelines enforced by our staff. They will allow your child the opportunity to receive the maximum benefits from therapy. Thank you for your commitment to your child and to achieving better health.

- Regular attendance is important for your child's progress.
- Late arrivals to appointments will reduce the amount of therapy your child receives, which will also negatively affect your child's progress.
- If you are going to be late to therapy, please call the clinic to see if you need to cancel.
- If you arrive 15+ minutes late for an appointment, your child might not be seen that day.
- If you need to cancel your appointment, please call at least 24 hours prior to your appointment.
- A "no-show" occurs when your child misses an appointment without calling the clinic prior to the beginning of the session. If the parent calls during the missed session, the absence is considered a "no-show".
- If you have two "no-shows" within an eight-week period, your child will be discharged from therapy.
- If you cancel *half* of your child's appointments consistently, your child will be discharged from therapy.
- The referring physician will be notified if your child is discharged from therapy.
- Running, climbing on furniture, rough play, food, and drinks are not allowed in the lobby.
- Due to infection control issues, toys will not be provided for siblings to use in the lobby. You are welcome to bring your own toys.
- You must stay in the office with your child until a therapist brings your child back for therapy. You may not drop them off in the parking lot or waiting room. If you leave during your child's appointment, you must leave a current cell phone number so you can be reached if needed.
- Please return to the office five minutes before the end of the therapy session. If you are late to pick up your child one time, you will lose the privilege of leaving the building during therapy.
- Child release policy: In the event your child will be picked up by someone other than yourself, we will need permission. Please list the individuals that you give consent to and provide at least 1 more working phone number in case of scheduling changes etc.
- The goal of our staff is to provide excellent service and care for each patient on an individual basis. In therapy, to assist your child in meeting goals and for safety, palpation and touching is required in assessing, treating, or directing your child during a treatment session.

Parent/Legal guardian: ____________________________________ Phone: ______________________
(Please Print)

Additional family/friends: Relationship: Permission to Consult: Yes/No

____ Phone: ________________________

____ Phone: ________________________

____ Phone: ________________________

To ensure patient safety we will be using a photo ID (facial recognition) and name for patient identification. You may bring in a most recent photo of your child that will become the property of Tidelands Health Pediatric Rehabilitation to be put in the patient's chart. Please submit headshots only. If you do not have a photo ID we will be asking name and date of birth as identifiers.

We appreciate your assistance in providing consistent and quality services for your child.

____________________________	___________	________________________	_______________
Parent/Caregiver Signature	Date	Therapist Signature	Date/Time

TIDELANDS HEALTH

PEDIATRIC REHABILITATION SERVICES

Conference Consent Form

Patient Name: ______________________________ DOB: ________________

Dear Parents and Caregivers:

In an effort to uphold HIPPA regulations and protect the privacy of your child, we ask that you indicate your post-session, preferred location of communication with your therapist. In addition, we ask that you:

- Are available, in the lobby, ten minutes prior to the end of your child's session.
- Temporarily exit the lobby if you are uncomfortable hearing information that other parents have elected to receive in this area.

[CHOOSE ONE]

_____ I elect to receive verbal consult regarding my child's session from the treating therapist in the lobby. The therapist will make every effort to consult in a discreet fashion; however, I understand the potential for others to hear the information being shared.

_____ I elect to enter the treatment area 5-10 minutes prior to the end of my child's session to receive consultation in private. I understand that I am responsible for entering the session and providing adequate time for consult.

________________________________ ________________________
Parent/Caregiver Signature Date

______________________________ ________________________
Therapist/Witness Date

Revised 10-24-19

TIDELANDS HEALTH
PEDIATRIC REHABILITATION SERVICES

ATTENTION

Illness can be especially dangerous for children with special needs. If a patient, parent, caregiver or sibling has experienced any of the following symptoms, we are kindly asking you to avoid entering our building.

- Fever within the past 24-48 hours
- Vomiting within the past 24-48 hours
- Diarrhea within the past 24-48 hours
- The flu
- Exposure to someone else with vomiting, diarrhea or the flu
- Productive and/or excessive coughing
- Colored nasal discharge

Please be respectful of our children and staff.   Please stay at home if anyone in your family or within your immediate contact has any of the symptoms listed above.

Discretion will be left to staff members and therapists with regard to treating children displaying the symptoms listed above.

Please sign acknowledging you have read the above information.

Patient Name: ___________________________ DOB: __________________

____ _______________________

Signature Date