Pediatric Registration Packet
Speech Language Pathology

Scan No. _____
Initials _______

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)		Marital Status: M S W D	
		Circle One: Female or Male	
Address		Social Security Number	Date of Birth
City State Zip Code		Email Address	
Best Contact Number	Emergency Contact Name/Number		

What type of appointment reminder do you prefer? □ Email □ Phone call

What format do you prefer for your rehab documents and home exercise program? □ Email □ Printed handouts

Are you receiving any nursing, aide, or therapy services in your home? □ Yes □ No *(If yes, notify the Front Office)*

For Medicare beneficiaries, have you received therapy in this calendar year? □ Yes □ No

Is this a Workers' Comp injury? □ Yes □ No **Date of Injury:** ____________ **Adjustor:** __________________ **Employer:** ________________

INSURANCE INFORMATION

Primary:	**Secondary:**	**Tertiary:**
Policy/ID#:	**Policy/ID#:**	**Policy/ID#:**
Name of Policy Holder:	**Name of Policy Holder:**	**Name of Policy Holder:**
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:
Date of Birth (Policy Holder):	Date of Birth (Policy Holder):	Date of Birth (Policy Holder):
SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):
Effective Date:	Effective Date:	Effective Date:
Group Number:	Group Number:	Group Number:
Below is an estimation of benefits. It may be subject to change based on your insurance.		
YTD Deductible $:	YTD Deductible $:	YTD Deductible $:
YTD Deductible Met $:	YTD Deductible Met $:	YTD Deductible Met $:
Co-Pay Per Visit $:	Co-Pay Per Visit $:	Co-Pay Per Visit $:
Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:
Insurance Coverage %:	Insurance Coverage %:	Insurance Coverage %:
Patient's %:	Patient's %:	Patient's %:
Total Visits Authorized: Visits Available: Auth End Date _____________ $ Limit_________________ **Are we in network?** □ **Yes** □ **No**	Total Visits Authorized: Visits Available: Auth End Date _____________ $ Limit_________________ **Are we in network?** □ **Yes** □ **No**	Total Visits Authorized: Visits Available: Auth End Date _____________ $ Limit_________________ **Are we in network?** □ **Yes** □ **No**

Dear Parent/Guardian,

For insurance to cover your child's treatment here, the following information is required.

Is your child receiving special services or therapy treatment from the local independent school district? □ **Yes** □ **No**

If **YES**, please provide a copy of your child's current IEP/ARD if receiving any services from your school district.
If **NO**, please complete the following statement:

To Whom It May Concern:

I am the parent/guardian of ____.
(Please Print Child's Name)

My Child is NOT receiving special services or therapy treatment from the local independent school district.

____________________________________ ____________________________________ _______________
Parent/Guardian Signature Parent/Guardian Printed Name Date

For our emergency records, please complete the following:

MEDICAL RELEASE

I, ___________________________________, Parent or Legal Guardian of _____________________________________
In my absence hereby authorize any Medical or Surgical treatment which may be necessary in an emergency situation while attending Integrity Rehab, for the wellbeing of the above mentioned minor. I agree to hold Integrity Rehab, the physician, and/or the hospital treating the above mentioned minor, harmless.

EMERGENCY MEDICAL INFORMATION

Drugs/Allergies/Special Medication Needs____

Chronic Diseases/Other Health Problems____

Pediatric Speech/Language History (1)

Patient Name: ______________________________
Date of Birth: ______________________________

Name of your Primary Care Physician: ____________________________ **Location:** ____________________

Indicate person/s child lives with: ___Father ___Mother ___Step-father ___Step-mother ___Other: ____________

Primary language spoken at home_______________ **Other languages used in the home**________________

Check reason/s seeking therapy services:

_____Articulation ____Feeding _____ Language _____Other: ________________________________

Describe your child's problem: ____

When did you first notice the problem?

Does anyone else in the family have a speech, language, hearing, or learning problem? ____Yes ____No

If **YES**, please **Describe:**____

Please list previous EVALUATIONS and results (Hearing, Speech and Language, Behavior, Sensory/Motor Skills)

DATE	LOCATION	EVALUATIONS	RESULTS

Please list DIAGNOSTIC TESTS (Hearing Tests, Laryngoscopy, Swallow Studies, Other) for current problem

DATE	LOCATION	DIAGNOSTIC TESTS	RESULTS

Check other professionals who are currently treating your child.

___ABA ___Nutrition ___PT ___Psychology/Psychiatry ___OT ___School Therapy ___Other: ____________________

Check the following CONDITIONS your child has been diagnosed with or is having current symptoms.

___ADD/ADHD	___Cerebral Palsy	___Grinding Teeth	___Rheumatoid Arthritis
___ADHD	___Depression	___Head Injury	___Ringing in ears/Dizziness
___Allergies	___Down's Syndrome	___Heart Problem	___Seizures
___Anemia	___Drooling	___Hearing Loss	___Spina Bifida
___Asthma	___Ear Infections	___Intellectual Disability-ID	___Stroke
___Autism	___Ear Tubes	___Kidney Disease	___Tuberculosis
___Birth Injury	___Emphysema/Bronchitis	___Multiple Sclerosis	___Other: ___________
___Breathing Problem	___Epilepsy	___Reflux	
___Cancer	___Fevers – high/prolonged		

Please explain any of the above as needed: ____

____

Pediatric Speech/Language History (2)

Patient Name: ______________________________

Date of Birth: ______________________________

Please list any hospitalizations, injuries, and other chronic or severe illness your child has experienced:

DATE HOSPITALIZATIONS/INJURIES/OTHER REASON

____

____

Please list all PRESCRIPTION (Rx) and OVER THE COUNTER (OTC) medications your child is currently taking (Include all injectable, oral, rectal, and topical medications):

____

____

HEALTH AND DEVELOPMENTAL HISTORY

Pregnancy health: ___Full-term ___Premature ___Any problems?______________________________

Describe your child's delivery and birth:

____Typical ____Spontaneous ____Induced ____Caesarian ____Breech ____Unusually long labor

What was your child's birth weight? _________________ **APGAR score ?**___________

What was your child's condition at birth?

____Typical ____ Birth Injury/Defect ____Jaundiced ____Breathing Problem ____Low Birth Weight ____Other

Developmental milestones: Child's age at:

Roll Over	Sit-up	Crawl	Walk Alone	Babble	First Words	First Phrases	Toilet Training

Does your child have a history of feeding problems? ____Yes ____No Check all that apply.

____Choking ___Difficulty Biting ___Difficulty Chewing ___Difficulty Swallowing ___Poor Nursing

SPEECH AND LANGUAGE

Did your child babble? ____Yes ___No, If YES, did he/she use a variety of sounds when babbling? ___Yes ___No

Is your child reluctant to communicate or become frustrated when trying to speak? ___Yes ___No

If YES, **describe:** ____

How would you describe your child's speech errors? ___Consistent ___Change from word to word and/or day to day

Circle the speech sounds your child currently uses:

Vowels: long a e i o u short a e i o u

Consonants: p b m w t d f v k g h

s z sh ch j y l r th

Approximately how much of your child's speech do you understand?

____Less than 25% ____25% ____50% ____75% ____100%

Can people outside the family understand your child's speech? ____Yes ____No

Integrity REHAB

Pediatric Speech/Language History (3)

Patient Name: ________________________________

Date of Birth: ________________________________

How would you describe the melody and rhythm of your child's speech? Check all that apply

____Smooth ____Slow ____Soft ____Halting ____Lacking in Intonation

____Choppy ____Fast ____Loud ____Lacking in Pitch Changes

How does your child typically communicate with others? Check all that apply

____Crying ____Facial Expressions ____Talking (whether understandable or not)

____Gestures ____Pictures ____Pulling/taking adult to what he/she wants

____Signs ____Pointing ____Voice output speech device

Does your child have difficulty following directions? _____Yes ____No

If YES, **describe:**____

If your child uses phrases and sentences, how long are they on average?

____2 words ____3 words ____4 words ____5 words ____longer than 5 words

Check Yes or No for the following:

Ask questions to gain information?	____Yes ____No	Understand vocabulary?	____Yes ____No
Use age-appropriate vocabulary?	____Yes ____No	Describe and explain?	____Yes ____No
Stay on subject in a conversation?	____Yes ____No	Answer questions?	____Yes ____No
Take turns when talking to someone?	____Yes ____No	Leave words out of a sentence?	____Yes ____No

Have difficulty putting words together into a sentence? ____Yes ____No

Use correct grammar such as plurals, verb tenses, and pronouns? ____Yes ____No

VOICE AND FLUENCY

Is your child's voice clear? ____Yes ____No

If No, **describe**:____

Does your child talk smoothly without repeating sounds or words?____Yes ____No

If NO, does he/she have trouble getting words out? ____Yes ____No

If YES, **describe:**____

AUDITORY PROCESSING AND LEARNING

Does your child have difficulty with any of the following? Check all that apply.

____Memory Tasks ____Comprehension ____Remembering and following directions

____Word Retrieval ____Putting thoughts together ____Difficulty learning or using new vocabulary

Is your child receiving special help with learning skills? ____Yes ____No

If yes, **describe:**____

What other concerns do you have about your child? ____

What do you consider to be your child's greatest strengths? ______________________________________

CONSENT FOR TREATMENT: I hereby authorize Integrity Rehab to provide therapy services to ____ that have been ordered by my (his/her) physician and are under the direct supervision of a licensed health care professional. I also understand that it is my (his/her) right to accept or refuse medical treatments.

AUTHORIZATION OF RELEASE OF INFORMATION AND PAYMENT: In applying for payment under Title XVIII or Title XIX of the Social Security Act, or other third party payer sources, I certify that the information given by me or a person authorized by me is correct. This authorization and request shall begin on _______________ (TODAY'S DATE), and continue until such time that it is revoked by me, my legal representative, physician or this clinic. I also agree if there are any changes to the billing information (i.e., change in insurance company or policy, becoming ineligible or eligible for Medicare and/or Medicaid, etc.) that I will notify the clinic immediately. If I fail to report changes with my insurance to Integrity Rehab's billing department I will be financially liable/responsible. I understand that I am financially responsible for all charges that my insurance company does not pay. I authorize the release of any information necessary in order to process any billing.

RELEASE OF INFORMATION/CONFIDENTIALITY: I hereby authorize any physician, hospital/medical facility, laboratory, or other health care provider to release to Integrity Rehab any information requested by them for the purpose of continuity of care. I also authorize Integrity Rehab to release any of my (his/her) health care information from them to other health care providers involved in my (his/her) care, or any facility where I (he/she) may be admitted for the purpose of continuity of care. A written consent from patient or legal representative is required to release medical information to persons not otherwise authorized by law (federal and state). **For pediatric patients I agree to the Pediatric Speech Therapy Procedures.**

NOTICE OF NON-DISCRIMINATION: Integrity Rehab does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, or national origin, or on the basis of disability or age.

GRIEVANCE/COMPLAINT PROCEDURE: Should I have a grievance or complaint; I understand that every attempt will be made to rectify the situation without fear of reprisal. I may contact the Clinic Director, Compliance Officer, or Administrator by calling (254) 699-3933 or emailing Compliance@IntegrityRehab.net. If the grievance or complaint is not resolved to my satisfaction, I may follow the printed "Consumer Information Notices" in the Reception area.

PHOTOGRAPHY: I **DO** ___ **DO NOT** ___ authorize Integrity Rehab to photograph, videotape, or audio record me (him/her) for medical education or reasons related to treatment and/or promotion of Integrity Rehab operations. Patient's name will not be used.

INFORMATION RECEIVED: I have reviewed a laminated copy of the following information to **read and understand:** 1) **Notice of Privacy Practices**, 2) **Cancellation and No-Show Policy,** and 3) **General Health** Guidelines**. I may request a copy to take home with me**. For **pediatric patients**, in addition to the preceding information, I have **reviewed** a laminated copy of **Pediatric Speech Therapy Procedures**.

In addition, the following NEW PATIENT INFORMATION is available upon request:

- Abuse, Neglect, and Exploitation
- Advance Directives
- Cell Phone Policy
- Children Policy
- Civil Rights
- Disaster/Emergency
- Employee Drug Testing
- Rights of the Elderly

I acknowledge that the information above has been provided to me or is accessible to me in my primary language, or via an interpreter. I certify that the information I have provided in this registration packet is accurate and complete.

____

Patient signature and date

____

Authorized agent signature and date **Relationship to patient**