If your child has an Individualized Education Program (I.E.P.) or an Individualized Family Service Plan (I.F.S.P) we are required to have a copy on file before future services can be provided. If you do not have a copy, please fill out the information below and we will request a copy.

Does your child have an IFSP? ☐ Yes ☐ No

*Who is your 1st Steps service coordinator?*_________________

Does your child have an IEP? ☐ Yes ☐ No

*What School District?*__________________________________

I, the undersigned, give Building Blocks Pediatric Therapy to request records for: ___________________________DOB:______________

____

Parent/Guardian Signature Date

5271 Getwell Rd., Southaven, MS 38672 | Phone 662.772.5924 | Fax 662.772.5925

A

Patient Name____________________________________

Date of Birth:________________ ☐ Male ☐ Female

Street Address____ Apt _______________

City___________________________ State___________ Zip Code _________________

B **Contact**

Mother/Guardian:________________________DOB:___________SSN:______________________

Occupation:___________________Phone:________________Email:__________________________

Father/Guardian:________________________DOB:___________SSN:______________________

Occupation:___________________Phone:________________Email:__________________________

Child Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other:____________________________

Languages Spoken in home:____

Names, ages & relationship of other family members in the household:

Name:________________________Age:________Relationship:___________________

Name:________________________Age:________Relationship:___________________

Name:________________________Age:________Relationship:___________________

Please list individuals with which we may share information regarding your child's treatment:

Name:___________________________ Relationship:_______________________________

Name:___________________________ Relationship:_______________________________

I Authorize Building Blocks Pediatric Therapy to communicate information regarding my child's treatment with the above person(s) as needed.

____
Parent/Guardian Signature

C **Insurance**

Primary Insurance Company:____

Policy Holder Name:__________________________________ Date of Birth:____________

Policy/ID Number:____________________________ Group Number:__________________

Secondary Insurance Company:____

Policy Holder Name:__________________________________ Date of Birth:____________

Policy/ID Number:____________________________ Group Number:__________________

Medicaid Only **(Including Magnolia, UHC, Molina)**

Medicaid Guidelines require your child to have an appointment with their referring physician every 6 months to continue receiving services. Please initial here acknowledging that you understand this. ______________

Physician/Specialists

Specialist	Name	Phone Number	Reason
PCP/Pediatrician			
ENT			
Audiologist			
Neurologist			
Psychiatrist			

Medical History

Medical Conditions/Precautions/Illnesses:

Procedures/Surgeries/Tests	When	Results
ABR/Bear Test		
Bone Density Scan		
CT Scan		
Ear Tubes		
Hearing Test		
Motility Study/Empty Scan		
MRI		
Psychological Evaluation		
Swallow Study		
Tonsils/Adenoids Removed		
Vision Test		

☐ Allergies ☐ Seizures ☐ Tube Feeding ☐ Baclofen Pump ☐ Shunts ☐ Vagal Nerve Stimulator

☐ Braces ☐ Asthma ☐ Cerebral Palsy ☐ Epi-pen carrier ☐ Autism ☐ Reflux

☐ ADD/ADHD ☐ Brain Injury ☐ Colic ☐ Hearing Aids ☐ Stroke ☐ Chronic Ear Infections

Other: ____

____

____

Current Medications, Vitamins, Herbs: ____

____

____

____

Check Boxes that apply **Birth History**

☐ Full Term Pregnancy ☐ No Pregnancy or Birth Complications

☐ Complications During Pregnancy/Delivery: ____

____

☐ Premature Birth— # of weeks Premature _______________ Birth Weight _______________

☐ Oxygen used — Length of time used: ____________________

☐ Feeding Tube — Length of time used:____________________

☐ NICU — Length of stay: _________________________

Please indicate the age that your child: **Developmental History**

Rolled Over________Sat Unsupported __________ Crawled___________ Pulled self to standing __________

Grabbed Toys__________Held Head unsupported ____________Walked unaided__________

Potty Trained___________Dressed Self __________Babbled_____________ Used first word__________

Fed Self_____________ Used Open Cup______________

Circle areas of concern: **Areas of Difficulty**

Chewing Drooling Swallowing Eating different textures of food Eating with utensils

Dressing Self Toileting Communicating Needs Handwriting Brushing Hair Brushing Teeth

Bathing Playing with Peers Entertaining self (without device) Using Scissors Balance

Following Directions Balance Hand/Eye Coordination Gets Frustrated Easily Sensory Processing

Other: ____

Circle what best describes your Child's primary way of communicating: **Primary Communication**

Non Verbal AAC Device Body Language Sign Language Phrases Single Words

Eye Gaze Pointing/Gesturing Sentences Facial Expressions Grunting Babbling

Other:____

Circle words that best describes your child: **Description of Child**

Active Affectionate Aggressive Calm Cautious Curious Demanding Distractible

Difficult to comfort Fearful Fearless Fussy Insecure Motivated Passive Persistent

Playful Shy Stubborn Withdrawn Avoids Eye Contact

Other:____

Feeding History

Does your child have a history of feeding or swallowing difficulties? ☐ Yes ☐ No

If Yes, Please Describe:____

Is your child on any special Diet or thickened Liquids? ☐ Yes ☐ No

If Yes, Please Describe:____

List your Child's Favorite Foods:____

What foods will your child not eat:____

Education History

Does your child attend School/Daycare? ☐ Yes ☐ No

Name/School District: ____

Grade: ____________________ List Any Grades your child has repeated:________________________________

Does your child have an IEP? ☐ Yes ☐ No

Please circle any services/therapies your child receives at school:

Speech Therapy Occupational Therapy Behavior Intervention English Language Services

Previous Therapy Services

Therapy Service	Where	When	Frequency/Duration
Behavior Therapy			
Occupational			
Physical Therapy			
Social Therapy			
Speech Therapy			
Other:__________________			

Additional Information

What are your goals for therapy? ____

____

What are your child's favorite Toys or Play Activities?________________________________

____

What other information would you like us to know about your child? ___________________

____

____

____

Patient Agreement

Consent for Care and Treatment: I, the undersigned, do hereby agree and give my consent for **Building Blocks Pediatric Therapy** to furnish medical care and treatment to: ______________________________ as it is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition. Building Blocks pediatric therapy has the right to discharge the patient for excessive cancellations or no shows.

Benefit Assignment: I, the undersigned, herby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private insurance and third party payers to entities doing business as **Building Blocks Pediatric Therapy**. A photocopy of this assignment is to be considered as valid as the original.

Financial Policy: We bill your insurance carrier solely as a courtesy to you. Your health insurance plan is a contract between you and your insurer. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of estimated share be made today. It is your responsibility to know when your plan coverage renews and your deductible will apply. If your insurance makes you responsible for any amount not collected up front, you will be responsible for the additional amount. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Building Blocks Pediatric Therapy.**

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contact at the time of service. It is important for those seeking therapy to understand what their insurance actually covered, and what it does not. Please note that most private/ commercial insurance companies do not cover diagnoses of developmental delay. It is your responsibility to know what your insurance covers. **Building Blocks Pediatric Therapy** is only given a generalized quote of benefits, not whether your Diagnosis is covered or not, if our treatment codes are covered by your plan, or whether it meets your insurance's criteria for medical necessity. Your insurance company makes the FINAL decision if services are covered, and whether a particular service is considered reasonable and necessary. Final determination is made when the claims are processed according to the plan's contact.

I, the undersigned, understand and agree that my health insurance company may deny payment for the reasons stated above. If my health Insurance company denies payment, I agree to be personally and fully responsible.

Outstanding Balances: Building Blocks Pediatric Therapy requires that all accounts be kept current. Payment is due at the time services are rendered, unless prior arrangements have been made with our billing staff. Payments must be made monthly to keep Your account current if payment arrangements have been made. Please contact our billing staff if you are unable to make a payment. Past due balances can result in termination of services from all therapy disciplines.

I, the undersigned, understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

______________________	______________________	______________________	______________
Patient Name	Parent/Guardian (print name)	Parent/Guardian (Signature)	Date

Therapy Guidelines

It is our pleasure at **Building Blocks Pediatric Therapy** to provide therapy services to your child. Home Exercise Programs and other suggested activities at home is a critical and necessary part of our services for your child to succeed. We require all of our therapists to give parent/guardian education when providing services to our patients. It is essential for the parent/guardian to be involved in the child's treatment plan for goals and achievements to be made.

Please review the following Therapy Guidelines:

1. For the safety and liability of the child, the parent/Guardian agrees to stay on the premises while the child is receiving therapy. This will also allow the therapist to involve the parent/guardian as needed in the child's therapy for parent education and hands on participation.
2. The parent/guardian agrees to cancel a scheduled treatment appointment by calling the office if fever, vomiting, or diarrhea has occurred within the previous 24 hours.
3. The parent/guardian agrees to contact the office if they are going to be late for the scheduled treatment appointment. If the patient is more than 10 minutes late, we will be unable to provide services, and the visit will be considered a no show.
4. To keep a reoccurring appointment on your therapist's schedule, we require an attendance show rate of 75% or better. If your child's show rate falls below 75%, we will notify the referring physician , and the child can be removed from the schedule at the discretion of **Building Blocks Pediatric Therapy.**
5. Following 2 no shows, the child will be removed from the schedule and a notification of non compliance will be sent to the referring physician. Services may be resumed at the discretion of Building Blocks Pediatric Therapy following communication from the parent/guardian. We consider a "No show" to be any appointment not cancelled within 2 hours of the scheduled appointment time.

Patient Consent for use and/or disclosure of Protected Health Information

I, the undersigned, herby states that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Jeff Moye Inc. dba Building Blocks Pediatric Therapy has been provided to me prior to my signing this Consent. The Privacy Notice provides a completes description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it's health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy notice prior to signing this Consent, and has encourage me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice Reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders or notifications that will be used by the practice:
A) Texting cell phone B) Email C) voice message to primary phone number

4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing by consent to the uses and disclosers described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient's Name (Printed)	Name of Parent/Guardian	Signature of Parent/Guardian	Date