Riggs Pediatric Therapy
11133 Interstate 45 South
Suite 190
Conroe, Texas 77302
(P) 936-494-0570
(F) 936-494-0571

Patient Information

Today's Date _____

Child's Name_____ Date of Birth_____

School_____ Grade_____ Age_____

FAMILY INFORMATION

Mother's Name_____ Father's Name_____

Mailing Address _____ Mailing Address_____

_____ _____

Occupation_____ Occupation_____

Work Phone_____ Work Phone_____

Home Phone_____ Home Phone_____

Cell Phone_____ Cell Phone_____

Email_____Email_____

Can we contact you by email regarding appointment times? Yes ☐ No ☐

Pediatrician_____Phone_____

INSURANCE

Insurance_____ ID Number_____

Subscriber Name _____Subscriber SS#: _____

Group Number_____ Subscriber DOB_____

Secondary Insurance_____ ID Number_____

HISTORY

1. Does the child live with **both** parents? If not, who does the child live with?_____
2. Have there been any major changes to the child's home/life in the past year? Yes ☐ ☐

If Yes, please describe:_____

_____

3. Has anyone else in the family or extended family had speech concerns? Yes ☐ No ☐

If Yes, please describe:_____

_____

4. Does the child have siblings? Yes ☐ No ☐

If Yes, please list:

Name _____ Age_____ Gender_____

 Patient Name:_____

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Name _____ Age_____ Gender_____

Name _____ Age_____ Gender_____

5. What is your child's overall physical health at this time?_____

6. Does your child have any known allergies? _____

7. Describe any complications during pregnancy and/or your child's birth. None ☐

_____

_____

8. Indicate all health previous health problems and age occurring: None ☐

Health Concern	Age Occurring

9. Does your child take any medications on a regular basis (including over-the-counter and prescribed)? Yes ☐ No ☐

If Yes, please list and explain purpose:_____

_____

10. Does your child have a special diet? Yes ☐ No ☐

If Yes, describe and explain purpose:_____

_____

11. Please describe any eating/feeding/sensory concerns:_____

_____

12. Please describe any physical concerns:_____

_____

13. Circle the following developmental skills that were considered delayed and indicate at what age the skill was mastered:

None ☐ (obtained developmental skills at appropriate ages)

Developmental Skill	Age Mastered	Developmental Skill	Age Mastered
Sitting Alone		Talking	
Crawling		Bowel/bladder control	

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Walking		Feeding/dressing self	
Other:		Other:	

*If any are checked, what was the identified reason for the delay? _____

14. What is the primary language spoken in the home? _____

15. Please explain any speech or language concerns._____

_____

16. Does your child have any problems getting along with others (siblings, friends, peers, adults)? Yes ☐ No ☐

If yes, please explain._____

_____

17. What does your child do in their free time when not in school?_____

_____

18. Check any of the following words that can be used to describe your child:

☐ happy ☐ unhappy ☐ moody ☐ cooperative ☐ withdrawn ☐ other:_____

☐ friendly ☐ quiet ☐ stubborn ☐ shy ☐ destructive

☐ aggressive ☐ overactive ☐ confident ☐ dependent ☐ independent

19. Has your child ever been retained a grade? Yes ☐ No ☐

If Yes, please list which grade and the reason? _____

_____

20. Briefly describe your child's strengths. _____

_____

21. Briefly describe your child's areas of concern. _____

_____

22. Has your child previously received services from a speech language pathologist or occupational therapist? Yes ☐ No ☐

If Yes, what were the goals of the therapy plan? _____

_____

Please explain any other information that you feel is important: _____

_____

How did you hear about Riggs Pediatric Therapy? _____

 Patient Name:_____

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Consent for Evaluation and Treatment

Child's name_____ Date of Birth_____

___Occupational Therapy ___Speech Therapy

_____ _____
Parent's Signature Date

Release of Information

I, _____, authorize Riggs Pediatric Therapy to release and obtain clinical information.

regarding: _____ (Patient's Name)

____Medical Information

____ School Documentation

____ Physician's notes

____ Other _____

to and from the following persons or agencies:

_____
Name Address Phone Number

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Credit Card Payment Authorization

I understand that Riggs Pediatric Therapy requires a card to be kept on file if therapy services require payment from the patient. _____Initial

I_____ Authorize Riggs Pediatric Therapy to keep and charge the credit card(s) on electronic file for any copays, no show fees, or balances that my insurance deems my responsibility. In the event a primary form of payment is declined I will provide an alternate form of payment. Failing to do so may result in cancelled upcoming visits due to non-payment.

Credit Card Information:

Cardholders Name: _____

Credit Card Number: _____

Expiration Date: _____ Security Code_____ Billing Zip Code_____

I certify that I am an authorized user of the credit card(s) on file, and I will not dispute the payments with the credit card(s) company, provided that the transactions correspond to the terms indicated on this authorization form.

_____

Parent/Guardian Signature Date

I authorize Riggs Pediatric Therapy to use my credit card on file in the manner listed below:

- I understand that if I do not call to cancel my evaluation 24 hours in advance my credit card will be charged the no show fee of 50.00. _____Initial
- I understand that copays, deductibles, or co-insurances will be charged at the time of check in. _____Initial
- I understand that any balances remaining after my insurance claim has closed will be emailed to me. Payments can be made online through your statement, or by calling our office. Any unpaid invoices remaining on the 15th of the following month will be automatically charged to my card on file (unless I have made a payment arrangement with the office otherwise). _____Initial
- I understand a No-Show fee of $50.00 will be charged to my credit card on file once the appointment is missed without notice. A receipt for each payment will be emailed to me. _____Initial

***Please note all emailed invoices will come from "Fusion Automated email."**

By signing this authorization, I acknowledge that I have read and agree to all the above information and warrant that the information above is true and correct.

_____

Parent/Guardian Signature Date

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Attendance Policy

We love spending time with our families and watching our patients bloom. For our patients to achieve the maximum benefit from our services, it is important to have consistent attendance. Our attendance policy is as follows:

We require cancelled and No-Show appointments to be rescheduled in order to maintain a monthly 80% attendance rate at our clinic. When cancelling an appointment, a call must be made to Riggs Pediatric Therapy 24 hours prior to the appointment to notify us that the patient will not be present. (Please no emails).

In the event that an appointment is canceled in less than 24 hours, the patient must reschedule a make-up session at the time of cancellation. The session must be made up within the next four business days, or a $50.00 fee will be charged to the card on file. _____Initial

When the patient No-Shows a scheduled appointment, it is required that the patient communicate with the office the same day as the No-Show to schedule a make-up appointment within four business days. If the office is not contacted on the day of the missed appointment, or the appointment is not rescheduled within four business days, a $50 fee will be charged._____Initial

Patients must maintain a monthly 80% attendance rate to retain their regularly scheduled appointment. Two consecutive months below 80% attendance will result in the loss of the patient's permanent appointment time and the patient will be moved to Drop-In Services. The above policy also applies to Drop-In patients. Once the patient has maintained 3 consecutive months of steady attendance (80%) they are able to be placed back on the schedule in a permanent spot.
_____Initial

Late Arrivals
We understand that delays happen, however we must try and keep other patients and our therapists on schedule. Speech and Occupational therapy patients must be seen no later than 10 minutes after the appointment time and will be charged the standard fee. In the event that a Speech or Occupational therapy patient arrives beyond this ten-minute mark, the patient must reschedule within four business days or incur the above $50.00 Fee. Reading/Dyslexia patients can be seen at any point during the appointment time and will be charged the full amount regardless of the start time of the session. _____Initial

Teletherapy
All the above policies apply to patients using Teletherapy services. _____Initial

On-Campus
The above policies apply to on-campus school therapy sessions as well. Additionally, the Riggs office, not the patient's therapist, should be notified of a child's absence, field trips, special events, or any school activity that interferes with the patient's therapy session. _____Initial

_____
Parent/Guardian Signature Date

Patient Name:_____

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Practice Policies

Assignment of Insurance Benefits: You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts, or any other patient responsibility indicated by your insurance carrier. _____ Initial

You are responsible for knowing your insurance policy. **For example,** you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Riggs Pediatric Therapy, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Riggs Pediatric Therapy are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Riggs Pediatric Therapy; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly. _____ Initial

Obligation of Account Balance: We make every effort to obtain the correct information regarding your obligation towards payment of evaluations and therapy, however you as the parent or guardian are ultimately responsible for any balance on the patient's account. You are responsible for paying your co-payment at or before the time of service. _____ Initial

Return Check Policy: Our return check fee is $50.00. This must be paid prior to your child's next therapy session. _____ Initial

Release of Information: The patient, parent or guardian authorizes Riggs Speech Therapy Services, LLC to release your child's health information to healthcare providers, insurers, or any other professional that could be liable for therapy charges. _____ Initial

Child Supervision Policy: Please be advised that in order to ensure the safety of your child, the parent/legal guardian is not permitted to leave Riggs Pediatric Therapy office while the child is in treatment. The parents must also be present and available to accompany their child to the back of the clinic to get water or use the restroom. _____Initial

Therapist Absence: Should your therapist be absent; your child will be seen at his/her regular appointment time with another therapist or notified and rescheduled. _____ Initial

*If you do not have insurance you may work with the billing department to schedule a payment arrangement.

_____Parent/Guardian Signature

Date

Patient Name:_____

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Notice of Privacy Practices

Effective Date: March 1, 2014

The privacy of all of Riggs Speech Therapy Services' patient's health information is important to us. This notice describes how health information about you or your family may be used and disclosed and how you can get access to this health information. Please review this notice carefully, sign and return the acknowledgement of receipt.

Riggs Speech Therapy Services, LLC is legally required to maintain the privacy of our patients and their family's health information. We are also required to provide you with this information regarding our privacy practices as described below. We reserve the right to change these privacy practices at any time as permitted by federal and state law. This notice is available to you upon request.

Uses and Disclosures of Health Information

We may use and disclose health information relative to treatment, payment, and healthcare operations

Treatment: With your permission, we may use or disclose your child's health information to a physician or other healthcare provider involved in your child's care. We may also discuss aspects of therapy programs within our staff to coordinate therapy between staff members or to discuss methods to maximize progress.

Payment: We may use and disclose your child's health information to obtain payment for services we provide to your child. This may include but is not limited to: evaluation reports, treatment notes, progress reports, or other documentation required by your health insurance company or flexible medical spending account.

Your Authorization: Information about you and your family's health will not be used for research, professional education, or marketing without explicit written authorization. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your family's health information for any reason except those described in this Notice.

_____Initial

Office Staff: Our office staff (e.g., office coordinator, bookkeeper) handles client and billing information. All office staff members are required to keep any information about our clients confidential.

PATIENT RIGHTS

Access: You have the right to access your own or your child's health information. You may view it on site or have us make photocopies. All requests for access must be in writing and an appointment time will be set. In certain circumstances we may deny your request, but we will tell you in writing of our decision and any reason(s) for a denial.

Restriction: You have the right to request additional restrictions regarding our use or disclosure of your own or your child's health information. All requests for additional restrictions to information must be in writing. We may deny your request under certain circumstances. The law allows information disclosure **without your authorization** in response to:

- court order, subpoena, warrant, or similar process,
- health oversight agencies,
- report about victims of abuse, neglect, or domestic violence, or
- public health activities.

Alternative Communication: You have the right to request that we communicate or send information to you at an alternate address or by alternate means (e.g. only by phone or only in person). Requests for alternative communication must be in writing and specify which location or method you prefer.

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Disclosure: You have the right to a written accounting of the instances in which Riggs Speech Therapy Services discloses your child's health information for purposes other than treatment, payment or healthcare operations. The list will not include disclosures made for national security purposes or to law enforcement personnel.

Healthcare Operations: We may use or disclose your child's health information as it relates to our healthcare operations. This may include operations such as performance reviews, staff and student training programs, and quality assurance and improvement.

Required by Law: We may use or disclose health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose health information to appropriate authorities if we have reason to believe that the client is a possible victim of abuse, neglect, domestic violence, or other crimes. We may use or disclose health information to the extent necessary to prevent a serious threat to the client's safety or health, or to the safety and health of others.

Appointment Reminders: We may use or disclose health information to provide an appointment reminder by voicemail, email, or letter. If you do not wish to have us leave messages at your work via email, or by any other means, please notify us in writing.

Authorization: In addition to our use and disclosure of health information about your child for treatment, payment, and healthcare operations, we may use your information for other purposes **with your written authorization**, e.g., videotaping for speech-language pathologist training. We do not use a client's health information for marketing purposes or communications without written authorization. You may revoke authorizations at any time. _____Initial

Riggs Speech Therapy Services cannot use or disclose health information for any reasons except those described in this notification without your written authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you want more information or have questions about our privacy policies and practices, please contact Lauren Riggs.

If you are concerned that your privacy rights may have been violated or if you disagree with a decision we have made regarding access to information or in response to a written request you have made, please contact Lauren Riggs at 936-494-0570. You may also submit a written complaint to the U.S. Department of Health and Human Services at 832-973-0022. Our office will provide you with the address upon request. Riggs Speech Therapy Services supports your right to the privacy of your child's health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I understand and have read the Notice of Privacy Practices.

_____ _____

Signature Date

Patient Name:_____

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Parent Authorization to Make Medical Decisions

I, _____, make oath and say that I am the lawful guardian of,

_____, and there are no court orders now in effect that would prohibit me from making medical decisions for the child listed above.

_____

Parent/Guardian Signature Date

A. The following people HAVE permission to make medical decisions for my child at Riggs Pediatric Therapy.

Child's Name	**DOB**	**Age**

1. Name: _____ Relation: _____ Phone: _____

2. Name: _____ Relation: _____ Phone: _____

This form is legally binding, so by signing it, you agree that all the information provided here in is correct. False Information will result in termination of contract, and you will forfeit your childcare retainer.

_____

Signature Date

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Patient E-mail and Text Messaging Permission Form

Riggs Pediatric Therapy provides our patients with appointment reminders via e-mail and text messages.

Riggs Pediatric Therapy believes strongly in protecting our patient's privacy. When you provide this information for us, we only use it to communicate with you. We do not share any patient information with any outside parties.

Please print all information clearly.

Name_____Date_____

E-mail_____

Cell Phone_____

I give Riggs Pediatric Therapy permission to send messages to me via e-mail and/or text messaging as a means of communication as indicated by my selection above.

Signature_____

Patient Name:_____

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M-CHAT

Please fill out the following about your child's usual behavior and try to answer every question. If the behavior is rare (you've only seen it once or twice), please answer as if your child does NOT do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes No
2.	Does your child take an interest _in other children?	Yes No
3.	Does your child like climbing on things, such as up stairs?	Yes No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes No
5.	Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes No
8.	Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?	Yes No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes No
10.	Does your child look you in the eye for more than a second or two?	Yes No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes No
12.	Does your child smile in response to your face or your smile?	Yes No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes No
14.	Does your child respond to his/her name when you call?	Yes No
15.	If you point at a toy across the room, does your child look at it?	Yes No
16.	Does your child walk?	Yes No
17.	Does your child look at things you are looking at?	Yes No
18.	Does your child make unusual finger movements near his/her face?	Yes No
19.	Does your child try to attract your attention to his/her own activity?	Yes No
20.	Have you ever wondered if your child is deaf?	Yes No
21.	Does your child understand what people say?	Yes No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes No

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PEDS Response Form

Child's name:_____ Parent's name:_____

Child's Birthday: _____ Child's Age: _____ Today's date: _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: NO YES A little Comments:

Do you have any concerns about how your child understands what you say?

Circle one: NO YES A little Comments:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: NO YES A little Comments:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: NO YES A little Comments:

Do you have any concerns about how your child behaves?

Circle one: NO YES A little Comments:

Do you have any concerns about how your child gets along with others?

Circle one: NO YES A little Comments:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: NO YES A little Comments:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: NO YES A little Comments: