1230 Johnson Ferry Place, Ste G-10
Marietta, GA 30068

Office 770-321-6705

Building Blocks Pediatrics, LLC

Therapy at its Best!

267 West Wieuca Rd NE, Ste 101
Atlanta, GA 30342

Fax 404-551-3891

Welcome to Building Blocks Pediatrics

Providing comprehensive therapy for your child

Please note that the following items MUST be completed, signed, and brought to the first meeting with your therapist:

1. New Patient Paperwork, including **Signed** Patient Services Agreement, **Signed** Authorization for the Release of Medical Records**, Signed** Permissions**,** Acknowledgement of the Receipt of Privacy Policy, and **Signed** Attendance Agreement.
2. A **PRESCRIPTION** from your child's primary care physician (with diagnosis code) for PT, ST, or OT Evaluation and Treatment. (This is extremely important so we can bill your insurance provider.)
3. A **PHOTOCOPY** of your insurance cards and driver's license or photo ID, front and back. (We can also make a copy of insurance card and ID in the office)
4. Any prior therapy notes, evaluation and or/or medical information that will assist us in treating your child.

Please bring all information listed above to your first appointment. Once your first appointment has been scheduled, the therapist will reserve this time for you and your child. Please call 770-321-6705 as soon as possible if you will be unable to attend. We look forward to meeting you!

<u>We have 2 convenient locations to serve you in North Atlanta</u>

1) East Cobb /Surrounding Areas: **1230 Johnson Ferry Place, Ste G10, Marietta, Georgia, 30068**
2) Buckhead/Surrounding Areas: **267 West Wieuca Road NE, Ste 101, Atlanta, Georgia 30342**

Building Blocks Pediatrics, LLC Summary of Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS OF UTMOST IMPORTANT TO US.

NEW PATIENT INFORMATION FORM

Child's Name (as it appears on insurance card): ____

Today's Date______________________ DOB ______________________ Gender M or F _________

Address ____ City ___________________ State _______ Zip____________

Home Phone Number _____________________________ Email____

Person filling out this form: _____Mother_____ Father _____ Stepmother _____ Stepfather_____ Other: _________

Mother's Name: ___________________________________ Cell Phone: ________________________________

Mother's Employer ________________________________ Work Phone _______________________________

Father's Name: ____________________________________ Cell Phone ________________________________

Father's Employer _________________________________ Father's Email _____________________________

Marital Status of Parents: ____________________________ Person with whom child resides:___________________

Primary Physician __________________________________ Physician Phone ___________________________

Referring Physician (if different)_________________________ Physician Phone ___________________________

Diagnosis (if known) ____

Please list all people living in household:

NAME	AGE	RELATIONSHIP TO CHILD	SPEECH/HEARING OR MEDICAL PROBLEM?
Primary Language spoken in the home:			

School/Preschool ____ Grade_____________

Does your child have an IEP or IFSP? ☐ Yes ☐ No

Does your child receive services through school? ☐ Yes ☐ No

Do we have permission to email you regarding your child's therapy services and billing? ☐ Yes ☐ No

PLEASE EXPLAIN THE CONCERNS YOU HAVE ABOUT YOUR CHILD?
(Include when this was first noticed and/or what may have caused it, etc. ______________________________________

____

____

____

Has anyone else expressed concerns (i.e., family members, pediatrician, teachers, etc.)?

____

Is your child currently receiving therapy services?

If "Yes", what kind, where and duration? ____

Has your child previously received therapy services? ☐ Yes ☐ No

If "Yes", what kind, where and duration? ____

Is your child adopted? ☐ Yes ☐ No Adoption Background ___________________________________

____

Medical History

At how many weeks was your child born? _____ Birth Weight? ______ Did your child go home as expected? ☐ Yes ☐No

Were there any complications during the pregnancy or delivery or immediately after? ☐ Yes ☐ No

Please describe: ____

List any unusual problems during first few weeks of life: ____

____

Has your child had his/her hearing checked in the past year? ☐ Yes ☐ No Date _____________

Has your child had his/her vision checked in the past year? ☐ Yes ☐ No Date _____________

Please list any hospitalizations and/or medical procedures:

____

____

History of Ear problems? ☐ Yes ☐ No

History of allergies, tonsillitis, or asthma? ☐ Yes ☐ No

Are there any diagnosed medical, physical, or emotional problems? ☐ Yes ☐ No

Have there been any serious illnesses, injuries or hospitalizations? ☐ Yes ☐ No

Does your child have any allergies? ☐ Yes ☐ No

Does your child take medication? ☐ Yes ☐ No

If yes to any of the above questions, please explain and give dates:___________________________________

____

Medications____

____

BEHAVIOR	AGE	COMMENTS
Sat up independently		
Crawled		
Walked Alone		
Spoke First Word		
Put several words together		
Dressed Self		
Finger fed self		
Ate with utensils		
Became toilet trained		

Does your child have any of the following?

Socializing Problems ☐ Yes ☐ No Feeding Problems ☐ Yes ☐ No

Sleeping Problems ☐ Yes ☐ No If you checked yes for any of the above, please explain:

____

____

____

Does your child get along with other children? ☐ Yes ☐ No Age of playmates ____________________

If no, please explain ____

How does your child usually let you know their wants/needs? _____________________________

Does your child communicate well with you/others? ☐ Yes ☐ No If no, please explain ________________

Does your child

Answer when you to talk to him/her? ☐ Yes ☐ No

Talk about what they are doing? ☐ Yes ☐ No

Ask for help? ☐ Yes ☐ No

What are your child's interests? (Favorite toys/activities/songs) ______________________________

____

Is your child enrolled in any community activities (music class, play groups, Mother's Morning Out Program?

____

Please list your goals for therapy: ____

____

____

____

Printed name of Parent/Legal Guardian____

Signature of Parent/Legal Guardian ______________________________________Date____________

I, ____________________________ (parent/legal guardian), knowing that ______________________________ (child's name) has a diagnosis requiring Occupational, Speech, or Physical Therapy treatment (OT, ST, PT) voluntarily consent to such care for the aforementioned child by Building Blocks Pediatrics, LLC as may be beneficial in the professional judgment of the child's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of OT, ST, or PT on my child. Parent Initials __________

I hereby authorize Building Blocks Pediatrics, LLC to bill my insurance company for direct reimbursement of therapy services rendered to my child. I understand that the patient/patient's family is financially responsible to pay all fees accrued (deductible, coinsurance, non-covered services, etc), regardless of insurance verification or if insurance refuses to pay provider a portion of the fees or in full. If an Automatic Payment Authorization is not in effect, I agree to pay all fees within 15 days after statement has been e-mailed. In the event of a returned or invalid payment, I agree to pay any additional associated banking, legal, and/or collection fees. I understand that I am ultimately responsible for payment of all services received. I understand that I am advised to fully know and understand my insurance benefits prior to my child receiving therapy services. All insurance plans are different, and it is impossible for Building Blocks Pediatrics, LLC to know the specifics of my plan and/or if my plan will reimburse for services received. Regardless of insurance verification or anticipated insurance coverage, I agree to pay all fees accrued for services received.

Parent Initials __________

I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills and performance components the therapist may need to address. I consent to use of gross motor play and exempt (hold harmless) my child, therapist(s), all employees and owners of Building Blocks Pediatrics, LLC, from any injury resulting from this type of play. Parent Initials _________

I am aware that Building Blocks Pediatrics, LLC is a teaching and learning facility. Students and other health care professionals come to this facility to learn and observe treatments being performed or led by my child's OT, PT, and/or ST. I give consent for other professionals and students to participate in treatment sessions. I have the right to withdraw this consent on any day if I choose to do so. Parent Initials __________

Parent/Legal Guardian Printed Name : ____

Parent/Caregiver/Guardian Signature: ______________________________Date__________________

Authorization for the Release of Medical Records

I, ________________________________ as personal representative of _______________________ (name of minor patient), hereby authorize Building Blocks Pediatrics, LLC to OBTAIN and RELEASE all of this patient's medical records, case records, case histories, and/or personal and regular files for the purpose of financial reimbursement, continuity of care and case management from and to all current and former providers of medical services (to include: primary care physician, psychologists, etc.). I understand and agree that a photocopy or facsimile of this executed authorization is as valid as the original.

Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization, and my consent has been made voluntary.

Printed name of Parent/Legal Guardian: ____

Signature of Parent/Caregiver/Guardian: ____Date ________________

Attendance Policy

Your child's progress depends on your family's commitment to therapy. When you schedule an appointment with our clinic, you are "reserving" the therapist's time. Therefore, we must strictly adhere to the following cancellation policy. Building Blocks Pediatrics, LLC's policy states that we require a 24-hour notice for cancellations. After a one time-time courtesy occurrence, a $50 cancellation fee will be charged for EACH missed therapy appointment. Please note that insurance cannot be billed for this fee, and you will be personally responsible for this charge. This fee may be waived if you are able to reschedule your missed appointment. If attendance becomes an issue and your child is unable to consistently attend their appointments, understand that we will need to discuss other options as we will be unable to hold your time slot.

Therapy time is very valuable, and the duration of therapy sessions are catered to your child's needs. Please arrive on time for your appointment and at least 5 minutes prior to the end of the session .

Parent/Legal Guardian Signature ____Date ______________

Acknowledgement of Receipt of Privacy Policy

I hereby acknowledge that I have read/received/downloaded a copy of Building Blocks Pediatrics, LLC notice of Privacy Policy Practices with an effective date of 4/14/03, as it relates to my child.

Name of Child ____

Name of Parent/Legal Guardian ____

Signature of Parent/ Legal Guardian ____Date:_______________

Permission for Family to Leave Site During Treatment

I understand that while my child receiving therapy, I may leave the premises. However, I agree to leave a working cell phone number where I can be reached during my absence. In addition, I agree that I will not travel more than ten miles from the facility and will return at least 5 minutes prior to the end of my child's session. I give consent and permission to Building Blocks Pediatrics for any additional treatment and/or transportation that may be needed in the event my child is injured or needs medical attention. I understand that failure to comply with the requirements listed above will result in immediate revocation of this ability. I also understand that the ability to continue to leave the premises while my child is in therapy is at the discretion of Building Blocks Pediatric Therapy and/or the therapist and may be revoked at any time.

I hereby release Building Blocks Pediatrics, LLC, and any agents as well as any assignees, from any and all claims for damages related to my leaving the premises during my child's therapy.

Child's Name ____ Cell Phone Number ______________________

Parent/Legal Guardian Printed name____

Parent/Legal Guardian Signature ____

Secondary Emergency contact Name/Phone Number ____

Photograph/Video

Photographs/videos are sometimes used for digital charts and may be used for education and training purposes (i.e. clinical supervision, conference presentations) and **with permission**, may be used by Building Blocks Pediatrics, LLC for marketing purposes. **Your child's name and information is always kept confidential.** I give permission for my child to be photographed/videod by Building Blocks Pediatrics, LLC.

Child's Name ____

Parent/Legal Guardian Printed name____

Parent/Legal Guardian Signature ____

Attendance Agreement

At Building Blocks Pediatrics, our greatest desire is to deliver the highest level of care to our patients. To maximize the benefits of therapy, consistent attendance is critical. Patient commitment to attend therapy as scheduled leads to better potential for patient progress. Missed and tardy appointments disrupt the therapist's schedule, slow your child's progress, and prevents other children from having the opportunity to receive services. Therefore Building Blocks Pediatrics asks that you agree to our attendance policy.

By initialing each item listed and signing below, you are indicating that you understand the attendance policy and the consequences of not keeping your child's appointments. We anticipate that you will adhere to the following:

________ 1. If I need to cancel an appointment, I agree to call at least 24 hours in advance. I understand that if I call after business hours, I may leave a voicemail with my child's name, therapy to be cancelled and reason for cancellation.

________ 2. I understand that missing an appointment without calling ahead is considered a "no show". I understand that calling within an hour of the appointment is still considered a "no show". I understand that after 2 "no shows", **my child will be removed from the schedule**. I understand that my child will also be removed from the schedule after 3 cancellations of any kind.

________ 3. I understand that if I arrive fifteen or more minutes late, I will not be seen that day and it will be considered a "no show".

________ 4. To avoid a "no show", I will refrain from scheduling other appointments around my scheduled therapy time.

________ 5. I understand that my referring physician will be notified if I am removed from the schedule due to inconsistent attendance.

________ 6. I understand that if my child is seen for 2 or more therapies on the same day and one therapist has to cancel, I am still responsible for bringing my child to his/her other therapies.

________ 7. I understand and will follow the treatment plan laid out by the therapists and approved by the referring physician, at home. The home exercise program is very important key to patient progress.

Child's Name ____ DOB_________________________

Parent/Legal Guardian printed Name ____

Parent/Legal Guardian Signature ___________________________________Date__________________