Pediatric Patient Registration:

Child's Full Name:_____

Date of Birth:_____ Age:_____

Address:_____

City:_____State:_____ Zip:_____

Is the patient a Foster Child? Yes / No

If yes:

Case Worker Name:_____

Email:_____

Phone:_____County:_____

Additional Information regarding care, contact, and restrictions:

_____

_____

Guardian Information:

Guardian's Name (1):_____

Address (If different from child's):_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Guardian's Name (2):_____

Address (If different from child's):_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Doctor Information:

Physician/Pediatrician (Name and Facility):_____

_____

Phone Number:_____Fax Number:_____

Parent/Guardian

Signature:_____Date:_____

By typing your name above you agree that your typed signature can be used as your actual signature.

Pediatric Medical History:

Birth History:

Delivered Via: □ Cesarean □ Vaginal If C-Section, was it planned? □ Yes □ No

Premature: □ Yes □ No If yes, gestation: _____weeks

Length of Pregnancy:_____ Duration of Labor:_____

Birth Weight:_____ Length:_____ List any complications:_____

Did the child require any of the following:

NICU: □ Yes □ No Special Care Nursery: □ Yes □ No

Oxygen: □ Yes □ No Incubator: □ Yes □ No

Medical History:

Please list other medical history/surgical history/hospitalizations:

_____

_____

Any Allergies? □ Yes □ No If yes please list:_____

_____

Please list any medications your child is presently taking:_____

_____

Has your child had hearing screened? □ Yes □ No If yes, what were the results?_____

Has your child had vision screened? □ Yes □ No If yes, what were the results?_____

Developmental History:

Sat at _____ months/years

Crawled at _____ months/years

Stood at _____ months/years

Ran at _____ months/years

Dressed at _____ months/years

Held head up at _____months/years

Walked at _____months/years

Toilet trained at _____ months/years

Fed self at _____ months/years

First single word at _____ months/years

Put words together at _____ months/years

Making sentences at _____months/years

Was placed on his/her belly as an infant	□ Yes	□ No
Enjoyed belly time as an infant	□ Yes	□ No
Was/is developmentally delayed	□ Yes	□ No
Is good with his/her hands (fine motor skills)	□ Yes	□ No

Please list any motor developmental concerns you have. (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement or heights, etc)

_____

_____

Behavioral/Social History:

Please check all that apply to your child:

- □Makes good eye contact with adults and peers
- □Is social and engaging
- □Is well behaved
- □Pays attention
- □Listens well
- □Plays well with other children
- □Does well with change
- □Understands safety
- □Takes turns with peers
- □Recalls and tells about day events
- □Maintains topic
- □ is aggressive
- □ Does not like new places/people
- □ Does not like crowds
- □ Prefers to play alone
- □ Has difficulty paying attention
- □ Has difficulty paying attention
- □ Is very busy and active
- □ Poor coping skills
- □ Unable to self-calm
- □ Extremely sensitive to criticism
- □ Follows directions
- □ Has tantrums

Please list any behavioral or social concerns:

_____

_____

_____

Please list any previous therapy evaluations completed and recommendations:

_____

_____

_____

Parent/Guardian

Signature:_____Date:_____

By typing your name above you agree that your typed signature can be used as your actual signature.

Occupational Therapy: If seeking occupational therapy for your child, please complete.

What are your primary concerns leading to an occupational therapy evaluation? _____

_____

Describe your child's attention to structured or unstructured play:_____

How does your child spend unstructured time? _____

Self Help: Has your child ever used feeding utensils? □ Yes □ No If yes, is assistance needed for success? _____

Physical Therapy: If seeking physical therapy for your child please complete this section.

What are your primary concerns leading to physical therapy evaluation?_____

_____

Has or does your child use braces or orthotics? _____

Has or does your child use any assistive devices? _____

Has your child seen an orthopedic doctors □ Yes □ No If yes, when/who/why:_____

_____

Speech Therapy: If seeking speech therapy for your child, please complete this section.

What are your primary concerns leading to a speech-language evaluation? _____

_____

Hearing: Has your child's hearing appeared normal: □ Yes □ No If no, please describe:_____

_____

Does your child respond to soft or moderate sounds?_____

Can your child follow instructions which are expected of his/her age □ Yes □ No

Speech and Language: Please provide age at which started and example for following categories:

1. Babbling: _____
2. First words: _____
3. Put 2 words together: _____
4. Put 3-4 words together: _____
5. Sentences: _____

Has the speech progress ever been interrupted or reversed? □ Yes □ No If yes please describe_____

When was the problem with speech/language first noticed? _____

Did it follow an illness, accident or unusual occurrence? _____

What is your primary language?_____

Do you or your child speak any other languages?_____

What is your and your child's preferred language? _____

Clinician Notes: _____

_____

_____

_____

Parent/Guardian Signature:_____Date:_____

By typing your name above you agree that your typed signature can be used as your actual signature.

HIPAA Release of Information Authorization Form

I hereby authorize *Michigan Orthopaedic Rehabilitation* (MOR) the ability to send me electronic communication containing my child's personal health information (information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to my child and which identifies my child's name, address, member ID, payment arrangements, and balance information) EXCEPT the following information about my child:

_____

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of: helping me to resolve claims or health benefit coverage issues, and the purpose of communication regarding plan of care.

I also allow the MOR staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of my child.

I understand that the electronic communication will be sent via an unsecured/unencrypted email network. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date listed below for one year.

I understand that I have a right to revoke this authorization by providing written notice to *Michigan Orthopaedic Rehabilitation*. However, this authorization may not be revoked if *Michigan Orthopaedic Rehabilitation*, its employees, or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my child's eligibility for benefits, enrollment, payment for, or coverage of services.

Parent/Guardian
Signature:_____Date:_____
By typing your name above you agree that your typed signature can be used as your actual signature.

Below please list the names and phone numbers of the parents/guardians you give permission to share your child's health information with.

Name	Relationship to Child	Phone Number

Release of Information Form

Child's Name: _____ Date of Birth: _____

This form allows *Michigan Orthopaedic Rehabilitation* to send and receive evaluations, reports, and other requested information, including sending claims to your insurance provider. If we do not have this form filled out, we will not be able to provide this service on your patient's behalf.

I hereby authorize any physician, clinic, hospital, institution, or school to release Medical and Psychological information regarding my child, (Patient's Name)_____ to *Michigan Orthopaedic Rehabilitation*. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize *Michigan Orthopaedic Rehabilitation* to contact any persons or institutions to obtain any additional information regarding my child when necessary.

I hereby authorize *Michigan Orthopaedic Rehabilitation* to release therapy reports regarding my child, (Patient's Name)_____, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the EXCEPTION of _____. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

Parent/Guardian
Signature:_____Date:_____
By typing your name above you agree that your typed signature can be used as your actual signature.

(OPTIONAL)
I give my permission for *Michigan Orthopaedic Rehabilitation* to photograph and/or videotape my child to use said photos and/or videos for promotional or educational purposes.
Please select one:

Agree
Disagree

Parent/Guardian
Signature:_____Date:_____
By typing your name above you agree that your typed signature can be used as your actual signature.

The release of information consent will expire in one year or after all billing issues related to this treatment will have been resolved. This consent may be revoked at any time through a written request to *Michigan Orthopaedic Rehabilitation*.

Pediatric Cancellation Policy

For pediatric appointments, we block an hour of the therapist's time. We ask to **PLEASE** give us a **24 hour notice** before canceling.

Please review and initial the following:

- A credit card MUST be kept on file: _____(initial)

  Credit Card#: _____ Exp. Date: _____
  CVV: _____ Zip Code: _____

- If appointment is **NOT** canceled within **24 hours**, there will be a **charge of $100** (Exceptions in case of an emergency) _____(initial)

- **Two** (24 hour) cancels within a month, there will be a **charge of $100 AND** patient will be taken off schedule (or must speak with treating therapist) _____(initial)

Parent/Guardian
Signature:_____Date:_____
By typing your name above you agree that your typed signature can be used as your actual signature.

Pediatric Appointment Reminders

Please check the best method of communication to contact you:

____ Voice Calls: Phone Number: _____
____ Text Message: Phone Number: _____
____ Email:_____

Please sign that we have permission to leave a voicemail/email you regarding your child's appointment or other treatment matters.

Parent/Guardian
Signature:_____Date:_____
By typing your name above you agree that your typed signature can be used as your actual signature.