Pediatric Boulevard, PLLC

● Physical: 2814 Gray Fox Road, Indian Trail, NC 28079 ● Correspondence: 2814 Gray Fox Road, Monroe, NC 28110
● Business: 704-821-0568 ● Fax: 704-821-0570 ● Email: info@pediatricboulevard.com ● Website: www.pediatricboulevard.com

PATIENT INFORMATION AND HISTORY

I. IDENTIFYING INFORMATION

Child's Name: _____ Gender _____
First Middle Last

DOB: _____ SS#: _____

_____
Street/Apt # City, State & Zip Code

Mother's Name: _____ Guardianship? **(Circle)** Yes / No
First Middle Last

DOB:_____SS#:_____ Authorized to receive patient information? **(Circle)** Yes / No

Address (if different from above):_____
Street/Apt # City, State & Zip Code

Home Phone:_____Cell Phone:_____

Employer:_____Work Phone:_____

Email Address:_____

How would you like for us to communicate with you regarding you child's services? **(Circle)** Phone Email Cell

Father's Name: _____ Guardianship? **(Circle)** Yes / No
First Middle Last

DOB:_____SS#:_____ Authorized to receive patient information? **(Circle)** Yes / No

Address (if different from above):_____
Street/Apt # City, State & Zip Code

Home Phone:_____Cell Phone:_____

Employer:_____Work Phone:_____

How would you like for us to communicate with you regarding you child's services? (**Circle**) Phone Email Cell

II. CONCERNS/HISTORY

Primary Concern/s (speech/fine motor/gross motor/etc.):

_____

_____

Please list any significant medical information (including any medications your child may be taking, allergies, etc.):

_____

_____

Have there been any recent changes in your child's development?

_____

_____

Has your child ever received therapy? YES NO
If yes, what types of therapy?_____
Is your child currently receiving therapy outside of Pediatric Boulevard (i.e., school, hospital)? YES NO
If yes, what types of therapy?_____
If you answered YES to the questions above, please provide name and address of provider/school:

_____

Does Pediatric Boulevard have a copy of the current: IEP, IFSP, or care plan from the other agency? Yes No***

_____

***** If you answered NO, then services cannot be provided until the documentation is received. *****
Pediatric Boulevard requires a copy of all other treatment plans from other agencies prior to initiating therapy services.

- *** If the child is a Medicaid recipient it is required by the state of North Carolina to provide the documentation.**
- *** In addition, Medicaid will not allow both agencies to perform therapy services on the same day.**

Primary Care Doctor/Name of Practice: _____
Phone: _____ Address:_____

Primary Insurance/Medicaid:_____
Name of Insured:_____Relationship to Child:_____
ID or Medicaid #: _____ Group #:_____
Address of Insured:_____ Phone:_____
Are Therapy Services covered under your current plan? YES NO

Secondary Insurance/Medicaid:_____
Name of Insured:_____Relationship to Child:_____
ID or Medicaid #: _____ Group #:_____
Address of Insured:_____ Phone:_____
Are Therapy Services covered under your current plan? YES NO

AUTHORIZATION TO RELEASE INFORMATION/PAYMENT OF INSURANCE BENEFITS: I hereby authorize Pediatric Boulevard, PLLC to furnish my insurance carrier/health plan any information it requests. I also authorize my insurance company/health plan to reimburse Pediatric Boulevard, PLLC directly for all covered services rendered.

Signature: _____Printed Name:_____
Relationship to Patient:_____
Date: _____

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CONSENT FOR EVALUATION & TREATMENT

Child:_____ DOB:_____

I,_____ give my consent for Pediatric Boulevard, PLLC, to provide
Parent or Legal Guardian

the following services indicated below:

____ consultation ____ evaluation ____ treatment

The purpose of this treatment is to help remediate the client's disorder(s)/delay(s) and/or behaviors.

I was given the benefits/risks/and alternative methods of treatment, and I understand that I can revoke my consent at any time. I understand that I can seek alternative methods of therapy if I am not satisfied with the services that Pediatric Boulevard offers.

***I have read and understand this authorization statement.

Signature	Printed Name	Relationship to Patient	Date

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Child's Name:_____DOB: _____

I,_____, hereby authorize Pediatric Boulevard, PLLC to release to:

- Physician (name)_____
- School System (name)_____
- Social Security Administration
- Medicaid
- Family Member (ex., mother and name) please specify:_____,
- Family Member (ex., mother and name) please specify:_____,
- Family Member (ex., mother and name) please specify:_____,
- Additional:_____

INFORMATION TO BE RELEASED (please provide a specific description of the information to be released):

_____

_____

_____Note:

By signing this authorization, you acknowledge that it extends to all or any part of the records designated above, which may include psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you.

PURPOSE OF DISCLOSURE:

□ Legal
□ Provider request
□ Insurance
□ Personal use
□ Changing providers
□ Other: _____

I understand that this authorization will expire on (please provide date or specify "no expiration"). If no date is provided, this authorization will expire one (1) year following the date of signature:

_____

I authorize Pediatric Boulevard, PLLC to release information as listed above:

_____	_____	_____	_____
Signature	Printed Name	Relationship to Patient	Date

The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at a later date if the information has not already been disclosed. We will not condition treatment or payment on your providing this authorization, except in the specific circumstances allowed by the HIPAA Privacy Rule. We cannot protect against the possibility that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by law.

******Reasonable copy fees may apply******

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FINANCIAL POLICY

Thank you for choosing us as your therapy provider. We are committed to providing you with quality and affordable therapy services. Our financial policy is outlined as follows:

Proof of Insurance: We ask that you present your insurance card to us at the first visit. If you are receiving services in the home, please provide a copy of your card to the therapist upon your first visit. You may also mail or fax a copy to this office. Please update us any time you have a change to your Insurance or Medicaid. It is your responsibility to provide any information regarding a change in address, phone numbers and employment.

Payment Arrangements: Your insurance company requires us to collect any co-payments, co-insurance and deductibles. For patients with a co-payment (i.e. $15, $20, etc. per visit) OR for patients whose co-insurance is based upon a percentage of the charge OR if you have a deductible that has not been met:

In-Clinic services: we require payment at time of service

In-Home services: you will receive a monthly invoice and payment is due upon receipt

Please understand that the amounts mentioned above are examples only and are determined by your benefit plan.

Non-covered Services. Please be aware that some or all of the services you receive may be non-covered by your benefit plan or not considered necessary by your insurer. You agree to pay for these services in full.

Methods of Payment: Credit Cards (Discover, MasterCard, Visa & American Express), Cash, Checks and Money Orders.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Discharge for Non-payment: Payment for services is your responsibility. We expect payment to be timely and in full. Non-payment (by you and/or your insurance company or benefit plan) may result in discharge from therapy services.

Cancellations/No Shows: If you need to cancel an appointment please call our office 24 hours in advance. Your child is expected to have a minimum of a 75% attendance rate per month. Non-compliance with this policy may result in discharge from therapy services. A note from your child's doctor will excuse a cancellation. (Accepting multiple notes will be at the discretion of the therapist.)

Tardiness: If your child is more than 10 minutes late to 2 scheduled visits, it is equivalent to 1 cancellation. Please see above regarding the discontinuation of therapy services as a result of multiple cancellations.

Return Check Fees: All returned checks (insufficient funds, stopped checks, etc.) will result in a $35.00 fee. Returned checks will not be processed. If this should occur, any additional payments must be made by cash or money order.

Collections: In the event that Pediatric Boulevard needs to consult a Collections Agency to collect an outstanding balance, the client will be charged an additional 25% fee (or the actual fee incurred by Pediatric Boulevard, if different) on top of the outstanding balance once monies are recouped

Signature:	Print Name:	Date:

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ASSUMPTION OF RISK, RELEASE AND INDEMNITY AGREEMENT

Use of all Clinical Equipment (i.e., equipment in gym, treatment rooms, pool, etc)

Name of Participant: _____

Pediatric Boulevard, PLLC, its trustees, employees, instructors, volunteers, agents, sponsors, and lessors (cumulatively, "Pediatric Boulevard") offers services and activities in and around, and use of, clinical fitness equipment and a swimming pool (the "Activity"). In consideration of Pediatric Boulevard allowing me (and/or my child) to participate in the Activity, I agree to the following:

Assumption of Risk: I understand that physical exercise, swimming, and other activities involving the pool and clinical equipment may cause personal injury, including but not limited to cardiovascular stress and death, as well as harm to personal property. I understand that participation in the Activity involves inherent risk, including unforeseen risks and risks imposed by other participants, and that participation is wholly voluntary. I acknowledge that I am solely responsible for determining and ensuring my (and/or my child's) physical, mental and emotional suitability to participate in the Activity. I (and on behalf of my child) assume all risks and accept responsibility for any property damage and loss, and for any personal injury, illness, disability, emotional distress, and death that I (and/or my child) may suffer as a result of participation in the Activity, whether described above or not.

Waiver and Release: I (and on behalf of my child) agree to forever release and discharge Pediatric Boulevard from any and all liability or claims I (and/or my child) may have for any property damage and loss, personal injury, emotional distress, illness, disability, and death, related to or arising from my (and/or my child's) participation in the Activity. This release is for any kind of claim, including breach of contract, fraud, or any other type of suit, and includes losses alleged to be caused by the negligence of Pediatric Boulevard to the fullest extent permitted by law, but does not include losses alleged to be caused by gross negligence.

Indemnity: I (and on behalf of my child) agree to defend, indemnify (meaning to pay or reimburse any amount required to be paid, including attorneys' fees) and hold Pediatric Boulevard harmless from all claims, causes of action, liability, losses, or damages for any property damage, property loss or theft, personal injury, disability, death or other loss brought by or on behalf of me, my child, a family member, my (and/or my child's) estate, another participant or spectator, or any other person, and arising from or relating to my (and/or my child's) participation in the Activity, including claims that Pediatric Boulevard was negligent.

Additional Provisions: I (and on behalf of my child) agree that the substantive laws of North Carolina govern this Agreement and any dispute I (and/or my child) may have with Pediatric Boulevard. I consent to exclusive jurisdiction in North Carolina, and agree that any mediation, suit or proceeding must be entered into or brought only in North Carolina. Any portion of this Agreement deemed unlawful or unenforceable is severable and shall be stricken without effect on the remaining provisions.

I have read this Agreement, I understand its contents and I sign it voluntarily. I intend by this Agreement to assume all hazards and risks, release all liabilities and claims, and indemnify Pediatric Boulevard for any claims arising from my (and/or my child's) participation in the Activity. I understand that this Agreement has no expiration date and remains in effect at all times that I am (and/or my child is) participating in the Activity and will be binding on me (and/or my child), my (and/or my child's) family members, heirs, assigns, executors, representatives, and estate.

Signature of Participant: _____ *Date*: _____

Parent or Legal Guardian (If Participant Is Under 18 Years of Age)

I hereby warrant that I have legal authority to act on my child's behalf. I agree to the above terms and conditions for myself and on behalf of my child. I agree to indemnify Pediatric Boulevard as provided in the Indemnity provision above for any and all claims brought by or on behalf of the child for whom I sign or for any claim brought by any other person related to the child's participation in or observation of the Activity.

Name of Parent / Guardian: _____ *Phone Number*: _____

Signature of Parent / Guardian: _____ *Date*: _____

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SICK POLICY

Fevers are common in young children and are often a signal that something is wrong. If your child has a fever of 101.0F or higher, please keep him or her home. If your child develops a fever of 101.0F or higher while at the clinic, you will be asked to bring him/her home. If your child's fever is *less than* 101.0 F, you will be notified and you may express your wishes to the staff at that time.

Our policy is that your child must remain free of fever for 24 hours before returning to the clinic, and area pediatricians agree with this policy. This means that if your child goes home at 3:00 p.m., but still has a fever at 6:00 p.m. or later, he/she cannot return to the clinic the next day. The 24 hours begins when your child's fever has broken and remains in a normal range.

Diarrhea and Vomiting

Diarrhea due to illness is highly contagious. If your child has diarrhea, please keep him/her home. If your child has a diarrhea episode, or any uncontained diarrhea while at the clinic, you will be asked to bring the child home. Our care providers use gloves while cleaning diaper soiled accidents. Please understand that germs from diarrhea can be spread through carpets, toys, swings and direct contact. It is very difficult to keep from spreading these germs to other children.

If your child vomits while at the clinic, you will be asked immediately to pick him/her up. Please keep your child at home until 24 hours after the vomiting has stopped. When children return too soon, there is a much higher rate of recurrence and contagiousness.

Coughs and Colds

Colds are a common occurrence. However, there are some symptoms that warrant keeping a child home. These include, but are not limited to: bad cold with hacking or persistent cough, green or yellow nasal drainage, productive cough with green or yellow phlegm being coughed up. These symptoms may be present with or without a fever.

If your child has just a cold, please notify their therapist. We encourage extra fluids and proper hand washing. If there are cold medicines you know will make your child more comfortable, please administer before the therapist works with your child. If your child cannot participate in the ordinary daily routine, he/she is probably too sick to be at the clinic.

Rash

A rash may be a sign of many illnesses, such as measles or chicken pox. In infants, an external rash may be a sign that something is going on internally. Please do not send your child to the clinic with a rash until the doctor says it is O.K. to do so.

Doctor's O.K.

In some instances you will be asked to keep your child home until we have written permission from your doctor saying your child is well enough to return to the clinic. Please understand this is for your child's well-being along with the well-being of the healthy children at the clinic and their families.

Bringing Ill Children

If your child is not infectious and your doctor has said they may return to the clinic, but your child is still not feeling 100%, please see that we have everything to make him/her comfortable. Items such as extra clothing, pillows, blankets, medication, etc. are very helpful to your child.

Medications

If your child goes to the pediatrician and is prescribed medication, please keep your child home until they have completed 24 hours of antibiotic treatment. If your child is to receive antibiotics at the clinic, please bring in the *labeled* bottle from the pharmacy and a syringe or other measuring device. You can administer antibiotics and other medications to your child prior to treatment.

Contagious conditions such as Pink Eye or Lice

If your child appears to have an infectious or contagious condition, i.e. pink eye, head lice etc., you will be asked to take him/her home or to a pediatrician to get checked out. Please do not be offended if your child is too ill to stay at the clinic and you are asked to take them home.

If your child has had a rough night or previous day, please assess them before bringing them to the clinic. If you ever have any doubts about whether or not your child should be at the clinic, please do not hesitate to call and ask us. The clinic opens at 8:00 a.m. and we would be more than willing to help you make that decision before you have to drop off your child for the day.

We do understand and empathize with parents when their children are ill. It can be a very difficult, frustrating, and emotionally challenging situation when you are torn between a sick child and other obligations. Our staff also experiences these emotions and situations when they or their children are ill. These policies are designed to be fair to the ill child and their family, as well as our healthy children and their families. Please understand that we love your children and provide the best care possible for them, but we are not a sick clinic. We are hoping to control the amount of illnesses at the clinic and to keep everyone healthy and happy. If you ever have any questions or concerns, please do not hesitate to call and talk to us at any time.

We wish to express our sincere thanks to all of you who keep their sick little ones at home and comply with our policies. We appreciate your courtesy!

Sincerely,
Pediatric Boulevard Staff

_____ _____

(Signature of Guardian) Date Signed

_____

(Printed Name of Guardian)

_____

(Relationship to Patient)

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EMAIL AND TEXT MESSAGE AUTHORIZATION

I understand that:
(1) I have the legal right to only communicate with Pediatric Boulevard, PLLC staff using methods that protect the privacy of my (or my child's) Protected Health Information.
(2) I understand that communicating by email or text message is not secure. It is possible for people to intercept or read email or text messages without my knowledge or permission. Email and text messages can go to unintended recipients. They can be stored in electronic files. They can be used as evidence in court.
(3) If I authorize Pediatric Boulevard, PLLC staff to communicate with me using email or text messaging, I acknowledge that I do not have an expectation of secure and private communications as defined by HIPAA and other state and federal laws.
(4) Communicating by email or text messaging is optional. I understand there are alternative methods of communications with Pediatric Boulevard, PLLC staff that are more secure. I am voluntarily requesting this form of communication.
(5) I have the right to limit what kind of information staff can communicate using email or text messaging.
(6) Staff have the right to limit what they will communicate by text messaging, or to deny my request.
(7) Staff may not read email or text messages promptly, so I should call or go to the office if I need to talk with someone right away.
(8) In case of emergency, I should call 911 instead of sending an email or a text message.
(9) It is my responsibility to delete emails or text messages on my telephone or other device so that other people cannot read them.
(10) When I communicate with my therapist using email or text messaging, my therapist will record the communication in my medical record or chart, unless it is regarding appointment times.
(11) Text messaging should only be used for non-sensitive information. If my therapist tells me that we need to communicate in person or by talking on the phone, I will comply with the request.
(12) I may cancel this request/authorization at any time by notifying my therapist in writing. If I revoke my consent, it is only effective from the date my therapist receives my cancellation, and not retroactively. A revocation of my consent will not affect my ability to obtain future services. Pediatric Boulevard and its staff may also terminate this method of communication at any time, in their sole discretion.
(13) I have a right to receive a copy of this form.

I have elected to communicate with Pediatric Boulevard, LLC staff by email and/or text messaging. I understand the risk of communicating through these methods, in particular the privacy risks explained in this form. Staff is not responsible for messages that are delayed or not received. Email or text messaging is not a substitute for care and is used primarily for convenience.

_____	_____
Patient Name	Email Address
_____	_____
Signature	Text Messaging Number
_____	
Date	

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CONSENT FOR PHOTOGRAPHY/VIDEO CLIPS

Child:_____ DOB:_____

I_____, give my consent for Pediatric Boulevard, to take pictures/video clips of
Parent or Legal Guardian's Name

_____ for viewing in our lobby/clinic.
Child's Name

I have a right to receive a copy of this consent upon request. I understand that I will not receive any financial compensation for providing this consent. Pediatric Boulevard, PLLC will not condition treatment or payment on your providing this consent. I acknowledge that Pediatric Boulevard, PLLC cannot protect against the possibility of re-disclosure of this information and may no longer be protected by law.

Please Initial

I understand that I can revoke my consent at any time by providing written notice. _____

I understand that this consent expires in 5 years, unless specified by the parent/guardian. _____
(Please specify alternate date if you would like consent to expire _____) – Leave blank if you do not have a date

I understand that Pediatric Boulevard does not allow parental videotaping of my child's session due to HIPAA regulations, however, I may request that my therapist to video tape portions of my child's session, which is the at the discretion of the individual therapist. _____

***I have read and understand this authorization statement.

_____	_____	_____
Signature	Relationship to Patient	Date

OR

I hereby do not provide consent for Pediatric Boulevard to take pictures/video clips of my child:
(PLEASE SIGN BELOW IF YOU DO NOT WANT PICTURES/VIDEO CLIPS TAKEN OF YOUR CHILD)

_____	_____	_____
Signature	Relationship to Patient	Date

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AUTHORIZATION FOR COMMUNICATION OUTSIDE OF TREATMENT ROOMS

I understand that:
(1) I have the legal right to only communicate with Pediatric Boulevard, PLLC staff using methods that protect the privacy of my (or my child's) Protected Health Information.
(2) I understand that communicating outside of the treatment room is not secure. It is possible for people to hear converations regarding personal health information regarding my child's therapy.
(3) If I authorize Pediatric Boulevard, PLLC staff to communicate with outside of the treatment room, I acknowledge that I do not have an expectation of secure and private communications as defined by HIPAA and other state and federal laws.
(4) Communicating outside the treatment room is optional. I understand there are alternative methods of communications with Pediatric Boulevard, PLLC staff that are more secure. I am voluntarily requesting to discuss therapy progress in the lobby as a form of communication.
(5) I have the right to limit what kind of information staff can communicate by asking my therapist or other staff to disclose information regarding my child or services in private.
(6) Staff have a right to limit what they communicate outside of the treatment room regarding my child's therapy session.
(7) When I communicate with my therapist regarding my child, my therapist may document pertinent facts regarding the communication in my child's medical record.
(8) I may cancel this request/authorization at any time by notifying Pediatric Boulevard in writing. If I revoke my consent, it is only effective from the date Pediatric Boulevard receives my cancellation, and not retroactively. A revocation of my consent will not affect my ability to obtain future services. Pediatric Boulevard may terminate this method of communication at any time, in their sole discretion.
(9) I have a right to receive a copy of this form.

I have elected to verbally communicate my child's progress with staff members at Pediatric Boulevard, PLLC outside of the treatment room. I understand the risk of communicating through these methods, in particular the privacy risks explained in this form. Pediatric Boulevard is not responsible for information that is overheard by others in areas outside of the treatment room.

***I have read and understand this authorization statement.

_____	_____	_____
Signature	Relationship to Patient	Date

OR

I hereby do not provide consent for Pediatric Boulevard to communicate with me regarding my child's progress or therapy session outside of the therapy room:

_____	_____	_____
Signature	Relationship to Patient	Date

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DISCHARGE POLICY

Pediatric Boulevard provides occupational, speech, and physical therapy services. Our therapists provide treatment based on their scope of practice and the licensure statures of each of their practicing licensing boards. Pediatric Boulevard reserves the right to discharge patients for any reason, as determined solely by Pediatric Boulevard's therapists and staff. For example, services may be discontinued for the following reasons:

The patient has met treatment goals;
The patient has not met treatment goals, but progress is no longer measurable and skilled therapeutic services are no longer showing documented change in performance;
The patient's family has requested dismissal;
The patient has demonstrated or threatened severely violent behaviors that cannot be controlled within the skillset of our licensed therapists;
The patient has unexcused absences or tardiness which results in less than a 75% attendance rate per month as described in the Financial Policy;
The patient has not abided by the payment obligations described in the Financial Policy; or
There is a history of policy violations, as described below.

Discharge for Policy Violations

While Pediatric Boulevard may discharge a patient at any time, in its sole discretion, we typically follow a "three strikes" discharge policy for policy violations:

1st Violation	=	Verbal warning
2nd Violation	=	Written notice
3rd Violation	=	Discharge

Policy violations include, but are not limited to:
Limited participation such as frequent cancellations or non-attendance to scheduled appointments;
Failure to abide by any practice policy;
Failure to treat property or premises with respect: We ask that you treat our clinic as you would treat your home. Please clean up after your children in the therapy rooms, restrooms and lobby.
Failure to supervise: Children should ALWAYS be supervised in the lobby, hallways and in the restrooms. Please never leave your child unattended.
Failure to remain on the premises: You are required to remain on the premises at all times your child is in a treatment session. Violation of this policy may result in Pediatric Boulevard reporting your absence to local authorities, and may subject you to criminal penalties as well as patient discharge.
Our goal is to make discharge from therapy a positive experience for all children. Please let us know if you need assistance regarding additional community resources that may be helpful upon discharge. Your referral source and your child's physician will receive written notification upon discharge.

Please sign below to indicate you understand and agree to our discharge policy.

Signature of Guardian	Date Signed
Printed Name of Guardian	Relationship to Patient

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DEVELOPMENTAL/SENSORY HISTORY

This information is very useful in gaining a clear understanding of your child's developmental history. Please do not leave any portions of the form blank. We appreciate your time.

Child's Name: _____
First Last Nickname

Birth Date: _____

Siblings and Age: _____

Child's School and grade: _____

Referred By (name, profession): _____

Physician (name, address, phone #): _____

Medical Information

Has your child had any of the following? If yes, please describe and date.

Childhood diseases or illnesses: _____

Congenital abnormalities: _____

Surgery: _____

Serious Injury: _____

Casts or Braces: _____

Ear Infections: _____

Tubes in Ears: _____

Allergies: _____

Seizures: _____

Other: _____

Is your child currently receiving any medications / frequency of dosage: _____

_____

Has your child received any medications in the past for any of the above mentioned conditions: ____ Yes ____ No

If yes, what and when?

_____

_____

Are there any medical precautions the therapist should be aware of when working with your child: ____ Yes _____ No

_____

_____

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DEVELOPMENTAL/SENSORY HISTORY (CONTINUED)

Does your child have any assistive devices (glasses, casts, or wheelchair):_____

Has your child received other evaluations or treatments (occupational, physical, psychological, speech and language, neurology): _____Yes _____ No

Type Evaluation Date Professional's Name Dates of Therapy

_____

_____

Medical Diagnosis (if any):_____

Has child had vision test? _____Yes _____No When? _____

Has child had a hearing test? _____Yes _____No When? _____

What were the results of hearing and vision test?_____

Mental Status?_____

Does the patient have a special risk situation (example, suicidal/homicidal), if Yes please explain_____

_____

_____

Mother's Health During Pregnancy

Any infections/illness/stresses/or medications during pregnancy? _____Yes _____ No

Describe:_____

Any complications during delivery _____Yes _____ No

Describe:_____

Birth History

1. Full Term: _____Yes _____No Weight at birth: _____
2. Premature: _____Yes _____No Number of Weeks: _____
3. Breech (feet first) _____Yes _____No
4. Required forceps for delivery: _____Yes _____No
5. Required suction for delivery: _____Yes _____No
6. Have any birth injuries: _____Yes _____No Describe:_____
7. If known, apgar Scores: at one minute: _____ at five minutes: _____
8. Required intensive-care hospitalization: _____Yes _____No How long:_____
9. Jaundiced? ____ Yes _____ No Length of Treatment:_____

Pediatric Boulevard, PLLC

● Physical: 2814 Gray Fox Road, Indian Trail, NC 28079 ● Correspondence: 2814 Gray Fox Road, Monroe, NC 28110
● Business: 704-821-0568 ● Fax: 704-821-0570 ● Email: info@pediatricboulevard.com ● Website: www.pediatricboulevard.com

Infancy and Early Childhood

Did or does your child:

1. Have sleeping problems: _____Yes _____No If yes, describe:_____
2. Have feeding problems: _____Yes _____No If yes, describe:_____
3. Have Colic: _____Yes _____No For how long:_____
4. Prefer certain positions as an infant _____ Yes _____No If yes, describe:_____
5. Dislike lying on stomach: _____Yes _____No
6. Dislike lying on back: _____Yes _____No
7. Enjoy bouncing: _____Yes _____No
8. Become calmed by car rides or infant swings: _____ Yes _____No
9. Become nauseated by car rides or infant swings: _____Yes _____No
10. Go through "terrible twos": _____Yes _____No

Developmental Milestones

Give approximate ages if remembered, or comment on anything unusual

Roll over:_____Walk:_____Say words:_____

Sit alone:_____Chew Solid Food:_____Say sentences:_____Drink from a cup:_____

Crawl:_____

Was crawling phase brief? _____ Yes _____ No

Did child use a walker (rolling plastic seat) _____Yes _____No How often:_____

Experience hesitancy or delays in learning to go down stairs: _____Yes _____No

Playground participation: _____ Avoids _____ Takes Excessive Risks _____ Typical

Enjoys Birthday Parties/Play groups: _____ Yes _____ No Describe:_____

Bowel and Bladder

Does or did your child:

1. Have trouble learning urinary control? ____ Yes ____ No
2. Have trouble learning bowel control? _____ Yes ____ No
3. Continue to have accidents during the day until the age: _____
4. Continue to have accidents during the night until the age: _____
5. Seem to have difficulty registering the need to eliminate? _____ Yes _____ No

Sleep Patterns

Does/Did Child:

1. Have regular sleep patterns? _____Yes _____No

Describe: _____

2. Wake frequently during the night? _____Yes _____No

Describe: _____

3. Tend to be an early riser, up and on the go? _____ Yes _____ No

4. Have a difficult time falling asleep? _____Yes _____No

Play Skills

1. What are your child's favorite play things?

_____

_____

2. What does the child do with these toys?

_____

_____

3. Who does your child prefer to play with?

_____

_____

4. What activities does your child least enjoy?

_____

_____

5. Are there any things which your child tends to fear or avoid? _____ Yes _____ No If yes, describe:

_____

6. What extra-curricular activities is your child involved in (such as gymnastics, swimming, scouts, etc)?

_____

_____

***What do you hope to gain from this evaluation and/or treatment?**_____

_____

_____

_____	_____	_____	_____
Signature	Printed Name	Relationship to Patient	Date