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 (Page 1)

I. IDENTIFYING INFORMATION

Child's Name: _____ **Gender** _____
First Middle Last

DOB: _____ _____
Street/Apt # City, State & Zip Code

Mother's Name: _____ Guardianship? ☐ YES ☐ NO
First Middle Last

DOB: _____ Authorized to receive patient information? ☐ Yes ☐ No

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

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____ *** (please print clearly)

Father's Name: _____ Guardianship? ☐ YES ☐ NO
First Middle Last

DOB: _____ Authorized to receive patient information? ☐ YES ☐ NO

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

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____ *** (please print clearly)

***Pediatric Boulevard will use ALL email addresses & contact numbers provided to contact you regarding therapy services. Please review the Email & Text Authorization Policy for details ***

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

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PATIENT INFORMATION AND HISTORY (Page 2)

II. CONCERN(S)/HISTORY

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

_____

_____

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

_____

_____

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

_____

4) Has your child ever received therapy? ☐ YES ☐ NO
   a. If YES, what types of therapy?_____
5) Is your child currently receiving therapy outside of Pediatric Boulevard (i.e., school, hospital)? ☐ YES ☐ NO
   a. If YES, what types of therapy?_____
   b. If you answered YES to the questions above, please provide name and address of provider/school:
   c. _____
6) If age birth-5 years of age: Were you aware of the services offered through the state (CDSA/Public School System)?
   a. **If YES**: You are aware of the services and would like to continue with the evaluation from Pediatric Boulevard. (skip to question C)
   b. **If NO**: You were not aware & would like to be referred to the state agency. (You may stop completing forms)
   c. Does Pediatric Boulevard have a copy of the current: IEP, IFSP, or care plan from the other agency?
      MUST CHECK A RESPONSE if under 5: ☐ YES ☐ NO *** ☐ N/A

*****If you answered NO, then services cannot be provided until the documentation is received based on the requirements of the commercial insurance plan/Medicaid.*****

***Pediatric Boulevard requires a copy of all other treatment plans from other agencies prior to initiating services.**

*** If the child is a Medicaid recipient it is required by the state of North Carolina to provide the documentation.**

*** Medicaid will not allow both agencies to perform therapy services on the same day.**

CONSENT FOR EVALUATION AND/OR TREATMENT

Child:_____ DOB:_____

I,_____(Parent or Legal Guardian) give my consent for Pediatric Boulevard, PLLC, **provide the following services based on their scope of practice and the licensure statures of each of their practicing licensing boards:** * 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 of Parent/Legal Guardian	Name of Parent/Legal Guardian	Relationship to Patient	Date	Time

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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	☐ Personal use
☐ Provider request	☐ Changing providers
☐ Insurance	☐ Other: _____

I understand that This Agreement has no expiration date and remains in effect at all times that my child is participating in the Services **unless I specify an expiration date.**

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

_____	_____	_____	_____	_____
Signature of Parent/Legal Guardian	Name of Parent/Legal Guardian	Relationship to Patient	Date	Time

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 WAIVER OF RESPONSIBILITY

NOTE: If your Health plan indicates that they may not pay for services, then you agree to pay.

You are receiving this document because your insurance company may not pay for all of the services that you will receive during your child's session.

Some health policies will only pay for therapy services that are considered to be medically necessary and are considered "covered services". Covered services are defined in the member's certificate of coverage or group medical agreement. Every enrolled member of the plan is given access to these documents.

Services that Pediatric Boulevard may request that may not be considered a "covered service" may include, but are not limited to:

- Physical Therapy Treatment
- Occupational Therapy Treatment
- Speech Therapy Treatment
- Consultation
- Physical Therapy Evaluation
- Occupational Therapy Evaluation
- Speech Therapy Evaluation
- Other

If you have a concern or question about a service that may not be covered by your health policy, we encourage you to contact your insurance provider directly.

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.

I understand that my health policy may not pay for these services. By signing below, I acknowledge and understand that I am therefore solely responsible for the total amount of all costs for the services rendered by Pediatric Boulevard related to the procedure(s) and/or treatment(s) identified at the time of service. I agree to be personally and fully responsible for timely payment of the amount billed.

Signature of Patient/Legal Guardian: _____ Date: _____ Time: _____

Printed Name of Patient/Legal Guardian: _____

Relationship to Patient: _____

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Acknowledgement of ATTENDANCE POLICY

I have been given a copy of Pediatric Boulevard's **ATTENDANCE POLICY.** I have read the policy and I understand its contents. I sign it voluntarily and I understand that the policy may change any time. **This Agreement has no expiration date** and remains in effect at all times that my child is participating in the Services and will be binding on me and my child's (and/or my) family members, heirs, assigns, representatives, and estate. A photocopy of this Agreement shall be deemed effective as if it were an original.

I hereby warrant that I have legal authority to act on the Patient's behalf. I agree to the above terms and conditions for myself and on behalf of the Patient.

Signature of Parent/Legal Guardian	Name of Parent/Legal Guardian	Relationship to Patient	Date	Time

Acknowledgement of SICK POLICY

I have been given a copy of Pediatric Boulevard's SICK POLICY. I have read the policy and I understand its contents. I agree to provide a note from my child's Primary Care Physician to allow him/her to resume services if the illness was contagious. I sign it voluntarily and I understand that the policy may change any time. This Agreement has no expiration date and remains in effect at all times that my child is participating in the Services and will be binding on me and my child's (and/or my) family members, heirs, assigns, representatives, and estate. A photocopy of this Agreement shall be deemed effective as if it were an original.

I hereby warrant that I have legal authority to act on the Patient's behalf. I agree to the above terms and conditions for myself and on behalf of the Patient.

Signature	Relationship to Patient	Date	Time

Acknowledgement of EMAIL & TEXT AUTHORIZATION POLICY

I have been given a copy of Pediatric Boulevard's **EMAIL & TEXT AUTHORIZATION POLICY.** I have read the policy and I understand its contents. I give Pediatric Boulevard permission to contact me regarding therapy services or for payment purposes via any of the telephone numbers or email addresses that I have provided. This includes, but is not limited to: email, voicemail, pre-recorded message, automatic dialing system or text message. Contact may also be made by affiliate agencies to collect money that I owe. I sign it voluntarily and I understand that the policy may change any time. **This Agreement has no expiration date** and remains in effect at all times that my child is participating in the Services and will be binding on me and my child's (and/or my) family members, heirs, assigns, representatives, and estate. A photocopy of this Agreement shall be deemed effective as if it were an original.

I hereby warrant that I have legal authority to act on the Patient's behalf. I agree to the above terms and conditions for myself and on behalf of the Patient.

Signature of Parent/Legal Guardian	Name of Parent/Legal Guardian	Relationship to Patient	Date	Time

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Acknowledgement of AUTHORIZATION FOR: COMMUNICATION OUTSIDE OF TREATMENT ROOMS

I have been given a copy of Pediatric Boulevard's **AUTHORIZATION FOR COMMUNICATION OUTSIDE OF TREATMENT ROOMS POLICY.** I have read the policy and I understand its contents. 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 sign it voluntarily and I understand that the policy may change any time. **This Agreement has no expiration date** and remains in effect at all times that my child is participating in the Services and will be binding on me and my child's (and/or my) family members, heirs, assigns, representatives, and estate. A photocopy of this Agreement shall be deemed effective as if it were an original.

I hereby warrant that I have legal authority to act on the Patient's behalf. I agree to the above terms and conditions for myself and on behalf of the Patient.

Signature of Parent/Legal Guardian	Name of Parent/Legal Guardian	Relationship to Patient	Date Time

Acknowledgement of DISCHARGE POLICY

I have been given a copy of Pediatric Boulevard's DISCHARGE POLICY. I have read the policy and I understand its contents. I understand that Pediatric Boulevard's therapists provide treatment based on their scope of practice and the licensure statures of each of their practicing licensing boards. I understand the attendance policy and that Pediatric Boulevard reserves the right to discharge patients for any reason, as determined solely by Pediatric Boulevard's therapists and staff. I sign it voluntarily and I understand that the policy may change any time. This Agreement has no expiration date and remains in effect at all times that my child is participating in the Services and will be binding on me and my child's (and/or my) family members, heirs, assigns, representatives, and estate. A photocopy of this Agreement shall be deemed effective as if it were an original.

I hereby warrant that I have legal authority to act on the Patient's behalf. I agree to the above terms and conditions for myself and on behalf of the Patient.

Signature	Relationship to Patient	Date	Time

Acknowledgement of OBSERVATION SUITE RULES POLICY

I have been given a copy of Pediatric Boulevard's **OBSERVATION SUITE RULES POLICY.** I have read the policy and I understand its contents. **I understand and agree to the rules above and understand that I will lose my Observation Room privileges IMMEDIATELY if I break any of these rules.** I sign it voluntarily and I understand that the policy may change any time. **This Agreement has no expiration date** and remains in effect at all times that my child is participating in the Services and will be binding on me and my child's (and/or my) family members, heirs, assigns, representatives, and estate. A photocopy of this Agreement shall be deemed effective as if it were an original.

I hereby warrant that I have legal authority to act on the Patient's behalf. I agree to the above terms and conditions for myself and on behalf of the Patient.

Signature of Parent/Legal Guardian	Name of Parent/Legal Guardian	Relationship to Patient	Date Time

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CONSENT FOR PHOTOGRAPHY/VIDEO CLIPS

Child's name:_____DOB:_____

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

_____ for marketing and educational purposes.
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.
- I understand that I can revoke my consent at any time by providing written notice.
- I understand that this consent has no expiration date, 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 Time

ASSUMPTION OF RISK, RELEASE AND INDEMNITY AGREEMENT

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

I have been given a copy of Pediatric Boulevard's **ASSUMPTION OF RISK, RELEASE AND INDEMNITY AGREEMENT POLICY.** I have read the policy and I understand its contents. I sign it voluntarily and I understand that the policy may change any time. **This Agreement has no expiration date** and remains in effect at all times that my child is participating in the Services and will be binding on me and my child's (and/or my) family members, heirs, assigns, representatives, and estate. A photocopy of this Agreement shall be deemed effective as if it were an original.

I hereby warrant that I have legal authority to act on the Patient's behalf. I agree to the above terms and conditions for myself and on behalf of the Patient.

_____ _____ _____ _____ _____
Signature of Parent/Legal Guardian Name of Parent/Legal Guardian Relationship to Patient Date Time

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MEDICAL AND PAIN MANAGEMENT HISTORY (Page 1 of 3)

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

_____

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

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MEDICAL AND PAIN MANAGEMENT HISTORY (Page 2 of 3)

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: _____

History of Condition

How long has your child had these symptoms? _____ ○ weeks / ○ months / ○ years

Has your child received other services (PT, chiropractor, casting etc.) for this condition? ☐ Yes ☐ No

Describe: _____

Is your reason for referral the result of an accident or event? ☐ Yes ☐ No

Describe: _____

Has your child received any imaging (x-rays or CT Scan)? ☐ Yes ☐ No

Describe the test and any findings: _____

Does your child have any precautions? _____

Does your child participate in sports or activities? ☐ Yes ☐ No

Describe: _____

Is your child unable to participate in these activities due to their condition? ☐ Yes ☐ No

Has your child had unexplained weight loss or gain? ☐ Yes ☐ No

Has your child had any changes to their bowel or bladder function? ☐ Yes ☐ No

Does your child experience headaches, dizziness or double vision? ☐ Yes ☐ No

Describe: _____

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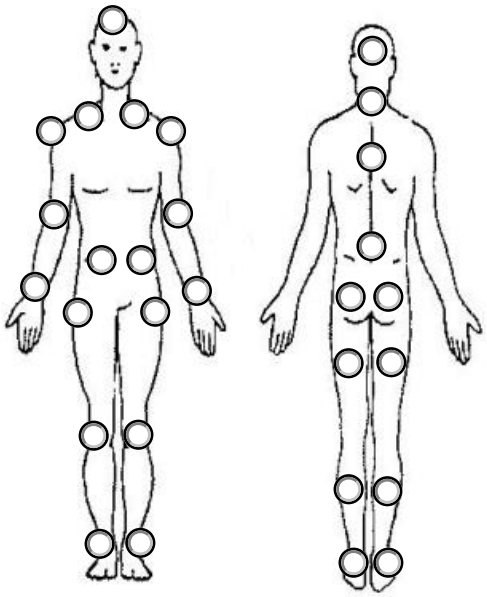
MEDICAL AND PAIN MANAGEMENT HISTORY (Page 3 of 3)

Symptoms

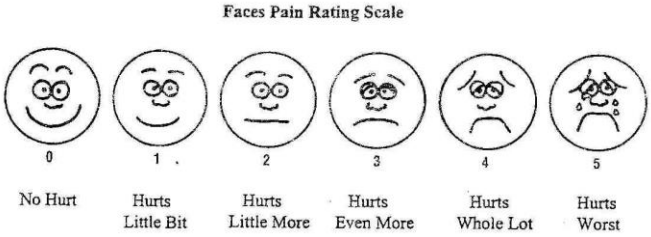
1. Is there a time of day, which your child's pain is worse? _____
2. Does your child's pain get worse before, during or after activity? _____
3. How does your child feel after waking up in the morning? _____
4. Use the body diagrams below to indicate the location of your child's pain:



/// : Pain
*** : Numbness, no sensation
+++ : Tingling, asleep, abnormal feeling

Pain Management

1. Has your child taken any medications to assist with the pain?: ☐ Yes ☐ No
   What medications and do they help: _____
2. Does your child use any of the following to alleviate the pain: ☐ Heat ☐ Ice
3. Please ask your child to rate their pain using the scale below: ☐ Worst ☐ Best



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

_____

_____

Signature _____ Printed Name _____ Relationship to Patient _____ Date _____