Account #:______________________________

Intake Information and Alternate Means Consent

Child's Information:	***Insurance Information:***
Name:	Insurance Company:
Date of Birth (DOB):	Insured Person:
Street Address:	DOB of Insured Person:
City: State: Zip:	Insurance ID #:
Diagnosis:	Group #:
Parent/Legal Guardian's Information:	
Mother/Legal Guardian:	Father/Legal Guardian:
Phone:	Phone:
Employer:	Employer:
City of Employment:	City of Employment:

Please Circle "Yes" if you are in agreement and enter apporpriate information:

Yes No May leave a detailed message with Primary Contact Person?

Ph: Name: Relationship to child:

Yes No May leave a detailed message with Secondary Contact Person?

Ph: Name: Relationship to child:

Yes No May leave a detailed message on voicemail at work?

Ph: Name: Relationship to child:

Yes No May leave information with another family member if you cannot be reached in case of emergency?

Ph: Name: Relationship to child:

Yes No May send clinic updates and information about your child to your email?

Email Address:

This allows Hillmann Pediatric Therapy to leave personal health information by alternate means. With my signature below, I acknowledge and understand that this information will be kept in my medical records and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify Hillmann Pediatric Therapy should I change one or more of the telephone numbers listed above.

______________________________________ ____________________

Patient, Parent of Legally Authorized Individual Signature Date

Please give the names of all service providers to the child. Examples are: pediatrician, neurologist, orthopedist, ENT, Occupational Therapist, Physical Therapist, etc.

Provider: ____________________
Type: ____________________
Address: ____________________
City: ____________________
State/Zip: ____________________
Phone: ____________________
Fax: ____________________

Provider: ____________________
Type: ____________________
Address: ____________________
City: ____________________
State/Zip: ____________________
Phone: ____________________
Fax: ____________________

Provider: ____________________
Type: ____________________
Address: ____________________
City: ____________________
State/Zip: ____________________
Phone: ____________________
Fax: ____________________

Provider: ____________________
Type: ____________________
Address: ____________________
City: ____________________
State/Zip: ____________________
Phone: ____________________
Fax: ____________________

School: ______________________________
Address: ______________________________
City: ______________________________
Phone: ______________________________
Teacher: ______________________________
Grade: ______________________________
Services Received: ______________________________

- I authorize Hillmann Pediatric Therapy, PC to exchange information pertaining to my child's care, which includes but is not limited to obtaining therapy prescriptions or other pertinent medical records related to therapy, forwarding copies of my child's Therapy Reports, and consultations with the Providers named above.
- I authorize Hillmann Pediatric Therapy to contact my insurance company in an attempt to verify benefits and obtain payment.

Signature: ______________________________ Date: ____________________

Parent / Legal Guardian of child

Therapy Attendance

Our goal is to provide you with excellent therapy services, ensuring the best possible outcome for your child's development. Frequent cancellations, late cancellations and no-shows interfere with the effectiveness of therapy, delay the accomplishment of therapy goals, and ultimately extend the duration of therapy required. For these reasons, we ask that you make a commitment to regular therapy attendance by your child.

We do not follow the school calendar. The clinic is open on many school holidays. If you are unsure whether your child will have therapy on a school holiday, please call the front office the day before in order to avoid a "No Show" fee being applied to your account.

Cancellations

Hillmann Pediatric Therapy requires a minimum 24-hour notice for all cancellations.

Frequent Cancellations
"Frequent cancellation" is defined as missing two consecutive appointments OR missing 75% or more of therapy sessions within a one-month period. If you frequently miss your regularly scheduled appointment, we reserve the right to move your child to an alternative timeslot or discontinue services.

Last Minute Cancellations
"Last minute cancellation" is defined as failure to notify the front office at least 24 hours prior to your scheduled appointment. We reserve your scheduled therapy time exclusively for you. Last minute cancellations result in lost therapy time for your child, and open timeslots which are difficult to fill with other clients. Please notify us as soon as possible for planned absences such as vacations, camps, medical leave, etc.

No-Show
"No-show" is defined as missing a scheduled appointment without notifying the front office, before the start time of your scheduled session.

Last minute cancellations and no-shows are assessed a $35.00 fee. All account payments are applied to last minute cancellations and no-show charges first, with the remainder of the payment applied to therapy service charges.

Sickness/Hospitalizations

Your child must be free from a fever, diarrhea and vomiting for at least 24 hours before coming to therapy. If your child exhibits these symptoms the day before your scheduled appointment, you are required to follow the "24-hour notice" cancellation policy (see above). If your child has been hospitalized 24 hours or longer (illness or surgery), a new prescription from the doctor is needed to reinitiate therapy. Our office will work with you regarding your child's therapy schedule if hospitalization occurs. Upon return to therapy, we require that you bring the prescription stating the reason for hospitalization, and that is ok to restart therapy services.

_______I will have my child attend on a regular basis and will give 24-hour notice if not attending.

_______I understand there is a $35.00 charge for late cancellations and no-shows.

_______If my child is hospitalized, I understand that I need to bring in a new prescription.

I have read, understand, and agree to follow the above policies related to therapy attendance.

_______________________________ _____________________
Parent's/Guardian's Signature Date

Billing and Payment Procedures

Billing Procedures

As a courtesy, we will submit claims to your insurance company. If your insurance requires medical records, we will provide the requested information, and regularly follow-up with the insurance company to ensure timely processing of the claim.

It is imperative that you know your insurance benefits and are involved with your insurance company to ensure timely payment. If a claim is unpaid after 30 days, we ask that you call your insurance to inquire about the delay in processing. Please notify our office if your insurance requires additional information from Hillmann Pediatric Therapy.

If we do not receive payment from your insurance within 90 days of submitting the claim, charges for that service are your responsibility.

Payment Procedures

Monthly Statements
Your monthly statements show charges and payments posted to your account. The statement clearly identifies what portion of your bill is "patient responsibility", which is due in full upon receipt of your statement. Charges you may owe include deductible, copayments, coinsurance, and charges your insurance has denied. Services that do not show "patient responsibility" on the statement are still processing with insurance, and do not yet require payment from you. Therapy sessions which have been paid in full will not be shown on your statement.

Account Payments
We accept cash, check or credit card payments and ask that you return the bottom portion of your statement with your payment. We also accept credit card payments online at www.HPTKids.com. **Please include your Patient ID, and client last name in the comments section.** The front office administrator will monitor your balance and request payments at your normally scheduled appointments, if applicable.

Finance Charges
Statement balances older than 90 days will result in finance charges of 1.5% per month (18% annually), added to your account quarterly. Statement balances older than 120 days will result in suspension of therapy services until the balance is paid in full. Statement balances older than 150 days will be subject to collection action, unless a payment plan has been established and is being followed consistently. (Please note payment plans are still subject to finance charges if not paid off after 6 months).

Suspension of Therapy Services
If the "patient responsibility" portion of your monthly statement exceeds $1000, your child's services will be suspended. Services will be reinstated once an agreed upon payment is made.

Copayment Policy
It is the policy of Hillmann Pediatric Therapy that co-pays are to be paid at the time of the visit, before the session begins. If you are unsure of the amount of your co-pay please check with the office staff.

Self-Pay Policy
If you do not have insurance, or your insurance doesn't cover your child's therapy, it is the policy of Hillmann Pediatric Therapy that self-pay sessions are to be paid at the time of the visit, before the session begins.

____
Parent Initial

Credit Card Authorization - Payment Plan
We offer a payment plan to assist you in making payments toward your account balance. By completing the attached Credit Card Authorization, you allow us to keep your credit card information securely on file and charge your credit card on a monthly basis. The amount of the monthly payment will be specified in the agreement. Once your balance is paid in full, the authorization will be shredded.

Non-Sufficient Funds (NSF) Charges
If you present Hillmann Pediatric Therapy with a check, and the check is returned due to non-sufficient funds, your account will be charged $25.00 for the first occurrence and $50.00 per occurrence thereafter.

Discontinuance of Services Agreement
When your child has completed therapy and is being discharged from services, you will meet with a clinic representative to discuss financial responsibility and payment of any outstanding balance.

Consent to Assign Benefits

I hereby assign all medical benefits to which I am entitled to Hillmann Pediatric Therapy in the event they file insurance on my behalf. <u>I understand that I am financially responsible for all charges whether or not paid by said insurance.</u> In the event my account becomes delinquent and is, therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid patient balances over 90 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Hillmann Pediatric Therapy as may be dictated by prudent medical practice by my child's illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

_______I understand it is my responsibility to know my insurance benefits and be involved in obtaining payment.

_______I understand that my balance is due in full upon receipt of my statement each month.

_______I understand that if my statement balance (patient responsibility) exceeds $1000, my child's therapy will be suspended until an agreed upon payment is made.

_______I understand that any unpaid balances older than 90 days will be subject to finance charges.

_______I understand that co-pays and self-pay sessions are to be paid at the time of service.

_______I understand that I am financially responsible for all charges.

_________________________________   _________________________
Parent's Signature   Date

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Hillmann Pediatric Therapy, P.C. LEGAL DUTY

Hillmann Pediatric Therapy, P.C. is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow this information practices that re described therein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Hillmann Pediatric Therapy, P.C. uses your personal health information primarily for treatment, obtaining payment for treatment (including collection agency if necessary), conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Hillmann Pediatric Therapy, P.C. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Hillmann Pediatric Therapy, P.C. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Hillmann Pediatric Therapy, P.C.' policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Hillmann Pediatric Therapy, P.C. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our facility. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENTS INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Hillmann Pediatric Therapy, P.C. will consider all such request on a case-by-case basis, but the company is not legally required to accept them.

I have read and fully understand and hereby consent to the use and disclosure of my personal health information for purposes as noted in Hillmann Pediatric Therapy, P.C.' Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying Hillmann Pediatric Therapy in writing at any time.

____________________________________ _______________
Parent/Guardian Signature Date

CONCERNS AND COMPLAINTS

If you are concerned that Hillmann Pediatric Therapy, P.C. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Hillmann Pediatric Therapy, P.C.' health information practices, or if you have a complaint, please, please contact the following office:

HIPAA Compliance Office
Hillmann Pediatric Therapy, P.C.
850 Brook Forest Ave. Unit L
Shorewood, IL. 60404
815-730-1800

Authorization to Render Emergency Services to a Minor Child

I, ________________________, give my permission for Hillmann Pediatric Therapy to obtain emergency and or medical attention for my child in case of an emergency while my child is receiving treatment at Hillmann Pediatric Therapy. I hereby release and hold harmless Hillmann Pediatric Therapy from any responsibility for any emergency care sought per my permission via the Emergency Release.

______________________________________ ____________________

Parent's/Guardian's Signature Date

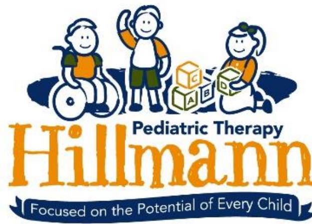
Policy on Restroom Use

We ask that you take your child to the restroom prior to the therapy session to maximize the therapy time your child has available. If your child needs to use the restroom during the therapy session and you are not available to take them to the restroom, Hillmann Pediatric staff will escort your child and assist as necessary. I understand that the time required to do this will be considered part of therapy time.

I have read and agree to the above policy on restroom use.

______________________________________ ____________________

Parent's/Guardian's Signature Date



1715 Dekalb Avenue, Ste. 125, Sycamore, IL 60178

Ph: (815) 991-5760 Fax: (815) 991-5766

Developmental History Form

Patient's Name: ______________________________ Date of Birth: ____________________

Age: _________ Primary Language Spoken in Home: ______________________________

Other Languages spoken in home: ____

Is this child: ☐biological ☐foster ☐adopted

Parents/Guardians Full Names: ____

Are Parents/Guardians currently: ☐married ☐ separated ☐divorced ☐never married

Who resides in primary home? ____

Siblings and Ages: ____

Referred by: ____

Person who is completing this form: ____

Birth History (check all that apply):

Mother's Pregnancy	**Child's Delivery**	**Child's Condition at Birth**
☐ No Complications ☐ Premature labor ☐ Diabetes ☐ Measles ☐ Toxemia ☐ Strep ☐ Respiratory ☐ Blackouts ☐ Falls ☐ Physical injury ☐ Excessive bleeding ☐ Hypertension ☐ Drug or Alcohol use ☐ Tobacco Use ☐ Other (Please specify): ____________________ ____________________	☐ Normal ☐ Induced Labor ☐ C-Section ☐ Emergency ☐ Forceps ☐ Vacuum ☐ Medications given during labor/delivery: ____________________ ____________________ ☐ Other (Please specify): ____________________ ____________________	☐ Normal ☐ Birth Weight: ___________ ☐ Birth Length: ___________ ☐ Premature ☐ Gestational Age: _________ ☐ APGAR Score: ▪ 1 minute:___________ ▪ 5 minutes:__________ ☐ NICU: # of days __________ ☐ Jaundice ☐ Heart Problems ☐ Poor Suck ☐ Small for gestational age ☐ Large for gestational age ☐ Other (Please specify): ____________________ ____________________

Family History:

Is there a family history for the following?	**Biological family member with the history…** (Mother/father, brother/sister, aunt/uncle, grandmother/grandfather, cousin, etc.)
Speech or language difficulties (articulation, stuttering, etc.)	
Receive Occupational therapy, Physical Therapy, or Speech therapy	
Developmental Disorder (Autism, developmental delay, etc.)	
Emotional concerns (depression, anxiety, mood swings, etc)	
Intellectual disability	

Child's Developmental Milestone History:

Please indicate the specific age or range when your child performed the following milestones.

Milestone	*0-3 months*	*4-6 months*	*7-12 months*	*13-18 months*	*19-24 months*	*2-3 years*	*3-4 years*	*Other (Please specify age)*
Lift head while on tummy								
Rolled over								
Sat without support								
Crawled								
Stood alone								
Walked alone								
Walked up stairs								
Started solid foods								
Spoke first word								
Spoke short phrases								
Spoke in sentences								
Stayed dry all day								
Stayed dry all night								
Gain bowel control								
Dress/Undress Self								
Button/zip clothes								
Held cup/used fork								
Drank from open cup								

Speech Development:

Please list the approximate age the child accomplished the following:	
Babble (dada, baba, mama, etc.)?	
Said first words?	
Start combining 2 or more words?	
How many words does your child have now?	

Does your child (check all that apply)....

- ☐ Respond when his/her name is called?
- ☐ Follow 1 step commands?
- ☐ Follow 2-3 step commands?
- ☐ Tell you what he/she wants?
  - How? ____
    ____

Check any areas of concern regarding speech/language (check all that apply):

☐ Length of statements your child uses	☐ Ability to sustain attention
☐ Ability to produce sounds correctly	☐ Ability to initiate a topic
☐ Ability to find the right word	☐ Ability to stay on topic
☐ Fluency of speech	☐ Ability to establish peer relationship
☐ Quality of voice (nasal, pitch)	☐ Ability to follow directions

When did you first notice difficulties with your child's speech and language? _______________

Does your child become frustrated due to these difficulties? _____________________________

Feeding:

Does your child have any feeding difficulty with the following (check all that apply):

☐ Poor suck	☐ Spoon use	☐ Touching foods
☐ Swallowing	☐ Fork use	☐ Crunchy food
☐ Chewing	☐ Required a feeding tube	☐ Messy food
☐ Gag often	☐ Reflux/Vomiting	☐ Overstuffs
☐ Choke often	☐ Refuse certain food textures	☐ Limited food repertoire
☐ Finger feeding		☐ Other: _________________

Has your child ever had a video fluoroscopy swallow study? Yes or No Date last performed:

Results:

Sensory/Behavior History:

During your child's **first few years of life**, were any of the following present? (Check all that apply)

- ☐ Did not enjoy cuddling
- ☐ Was not easily calmed by being held or being stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Frequent head banging
- ☐ Sensitive to touch
- ☐ Difficult nursing
- ☐ Poor eye contact
- ☐ Startled easily to sound
- ☐ Did not turn towards caregivers
- ☐ Did not respond to name
- ☐ Did not respond to speech of caregivers
- ☐ Fascination with certain objects
- ☐ Constantly into everything
- ☐ Did not tolerate tooth brushing

Check all that apply to your child **over the past year (check all that apply)**:

Attention	**Temperament**	**Emotional**	**Direction Following**
☐ Fidgets ☐ Easily distracted ☐ Hard time staying seated, ☐ Has difficulty waiting his/her turn ☐ Talks excessively ☐ Interrupts often ☐ Doesn't listen ☐ Poor Concentration ☐ Odd fascinations ☐ Difficulty transitioning between activities	☐ Impulsive ☐ Engages in physically dangerous activities ☐ Actively defiant to adult requests/rules ☐ Angry or resentful ☐ Easily frustrated ☐ Aggressive towards adults ☐ Aggressive towards peers ☐ Temper tantrums ☐ Rapid mood changes ☐ Explosive temper with minimal provocation	☐ Low energy/fatigue ☐ Immature compared to peers ☐ Excessive separation difficulties ☐ Shy ☐ Low Self-esteem ☐ Withdrawn ☐ Overly anxious/fearful ☐ Sleeping too little ☐ Cries easily ☐ Excessive need for reassurance ☐ Poor appetite ☐ Overeats ☐ Unrealistic worry about future events	☐ Difficulty initiating tasks ☐ Difficulty completing tasks ☐ Difficulty following instructions ☐ Often loses things ☐ Very disorganized compared to peers ☐ Difficulty making decisions

How often does your child have difficulty with the following?			
Getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
Eating dinner at dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
Playing with siblings/other children	☐ Rarely	☐ Sometimes	☐ Frequently
With babysitter or at daycare	☐ Rarely	☐ Sometimes	☐ Frequently
In public (store, restaurant, church, etc.)	☐ Rarely	☐ Sometimes	☐ Frequently
In the car	☐ Rarely	☐ Sometimes	☐ Frequently
During sit-down homework time	☐ Rarely	☐ Sometimes	☐ Frequently

Hearing / Vision:

Has your child ever had a vision test? Yes or No	If yes, date last performed _______________	
Results:		
Does your child wear glasses? Yes or No		
Has your child ever had hearing test? Yes or No	If yes, date last performed _______________	
Results:		
Does your child wear a hearing aid? Yes or No	If yes, please indicate what side Left Right	

Additional Information:

Please list your child's strengths

____

____

Please explain why you want this evaluation done ____

____

____

____

Is there anything else that you would like us to know about your child's development?

____

____

____

Educational History:

What school does your child attend? ________________________ Grade Level? _________

How often does he/she attend school? ____________days per week ________ hours per day

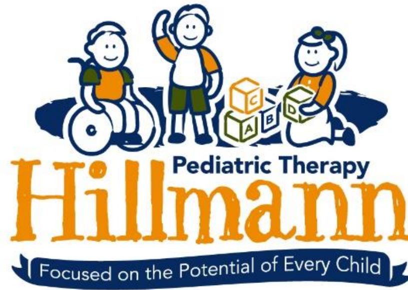
Please list areas of strength as well as areas of weakness for your child at school.

____

____

____

Thank you in advance for taking the time to complete this form. The information you provided is valuable in assessing your child's skills.



1715 Dekalb Avenue, Ste. 125, Sycamore, IL 60178
Ph: (815) 991-5760 Fax: (815) 991-5766

Medical History Form

Patient's Name: ________________________________ Date of Birth _______________
Person who is completing this form: ____

Child's Medical History

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Ear Infections
  - Frequency:
  - Ear Treatment Method: ____
- ☐ Seizures
  - Please describe and indicate frequency:
    ____
    ____
    ____
    ____
    ____
- ☐ Current with all vaccinations
  - If not, please explain:
    ____
    ____
    ____
- ☐ Other (please specify):
  ____
  ____
  ____
  ____
- ☐ BPD
- ☐ Reflux
- ☐ Allergies
- ☐ Tonsillitis
- ☐ Head Injury

Hospitalizations

List all hospitalizations:

Dates: Reason: Hospital:

_______________ ___________________________ _____________________

_______________ ___________________________ _____________________

_______________ ___________________________ _____________________

Surgery Performed

- ☐ Spinal Infusions
- ☐ Central Line
- ☐ Heart Repair
- ☐ Shunt
- ☐ G-tube
- ☐ Trach
- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Ear Tubes/Still in place? Y or N
- ☐ Orthopedic (please specify): ______________________________

Tests Performed

- ☐ MRI
- ☐ CT Scan
- ☐ X-Ray
- ☐ Genetic Testing
- ☐ Diagnostic Testing
- ☐ Other (please specify): ______________________________

Medications

Please list all medications/supplements:

____

____

Additional Information

Has your child had any previous evaluations / therapy? Y or N

If yes, please provide dates, facility where performed, type of therapy and reason(s) _________________

____

____

____

Is there anything else that you would like us to know about your child's medical history?

____

____

Please list any pertinent family medical history ____

____

____

Thank you in advance for taking the time to complete this form. The information you provided is valuable in assessing your child's skills.