

Dear Patients, Parents or Guardians,

Thank you for choosing Azalea Rehab Services. Our commitment to quality service as therapists includes documentation and following our professional and state-mandated guidelines.

Please complete the following packet to the best of your ability. In addition, please include a copy of your insurance card(s), front and back, and a copy of the patient's prescription if available. Upon returning your completed packet to our facility someone will contact you to set up an appointment.

- □ New Patient Registration Form (Front and Back)
- □ Copy of Insurance card (Copy of Both Sides)
- ☐ Prescription for Speech Therapy or Occupational Therapy (Duration & Frequency)
- □ Liability Release
- □ Release of Information (Copies of Current IEP and/or Evaluation)
- □ Welcome Sheet
- □ Private Insurance and /or DDD Authorization

Thank you!

From all of us at Azalea Rehab Services



2301 Bemiss Rd. Valdosta, GA 31602 Office: (229) 244-1667 Fax: (229) 244-8253

azalearehab@gmail.com

New Patient Intake Form

			M / F
Child's Legal Name	Child's Nickname	Date of Birth	Gender
Primary Care/Pediatrician			
Father or Legal Guardian		Mother or Legal Guardian	
Father's DOB		Mother's DOB	
Please check if it is ok to leave a message	Yes No	Please check if it is ok to leave a message	Yes No
	_ 🗆 🗆		
Home Phone		Home Phone	
Cell Phone		Cell Phone	
Work Phone	_	Work Phone	
Email		Email	
Physical Address		Physical Address	
City, State, Zip		City, State, Zip	
Occupation		Occupation	
Employer		Employer	
: If the primary person bringing the child to therap	oy is not listed above, please list t	heir name and contact phone number.	
Additional Authorized Contact Name		Phone	
Is there a joint custody or parenting plan in effectYesNo	? Is there a restraining	order in effect? If "yes", against whom is t	the restraining order?
INSURANCE INFORMATION (please complete a	ıll areas)		
Primary Insurance		Secondary Insurance	
Policy Number		Policy Number	
Group Number		Group Number	
Claims Address		Claims Address	
Phone Number		Phone Number	
Insured's Name		Insured's Name	
Insured's DOB		Insured's DOB	



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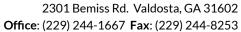
INSURANCE AUTHORIZATION

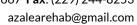
Parent/Legal Guardian Signature

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Parent/Legal Guardian Signature	Date
EMERGENCY MEDICAL RELEASE In the event medical attention is required for your chi implement treatment. Please read and sign statement	ild while the premises of Azalea Rehab Services (ARS), we need your authorization to t below.
As legal guardian ofpersonnel in the event of a medical emergency.	, I give my permission for Azalea Rehab Services to contact emergency
Parent/Legal Guardian Signature	Date
EMERGENCY CONTACT	
Name	Phone
Relationship	
MEDICATION/ALLERGIES/CONDITIONS Medications (Include prescription drugs, over the cou	unter meds, vitamins, and homeopathic medications):
Allergies/Reactions:	
Diagnoses (Any known medical diagnosis or medical d	condition, with dates of diagnosis if known):
PHOTO PERMISSION Please initial the following OPTIONAL statements:	
I give permission for photos/videos of m	ny child to be used for the purposes of treatment, education, and documentation.
I give permission for photos/video of my	y child to be used for advertising, brochure, and/or webspace.
TECHNOLOGY PERMISSION Please initial the following OPTIONAL statements:	
_ · · · · · · · · · · · · · · · · · · ·	ab Services to correspond with my child's legal guardians and care team via e-mail ramming. I understand that ARS e-mail is encrypted internally; however once an email is tercepted by an outside party.
AUTHORIZATION AND CONSENT FOR EVALUATION Please initial the following statements:	ON, TREATMENT, AND OPERATIONS:
	rmission to evaluate and treat my child, and I understand there will be written, oral, and nysicians, insurance companies, and Azalea Rehab Services staff.
	for the purpose of insurance certification or licensing and quality assurance may review onfidentiality will be followed in use of the information gathered.

Date







General Background

Do	Does your child ever complain of pain? If so, in what area? Please describe.				
Ple	ase list any medical precauti	ons/a	illergies/medication	ıs:	
ls y	our child receiving any other s	ervic	es (i.e. Speech Thera	py, Physica	l Therapy, Occupational Therapy, Special Education, Early Intervention)?
	nat (if any) special equipment Wheelchair Eye Glasses Hearing Aids		Braces Walker Crutches		Communication Device Other:
_					
	Premature (Gestation:		weeks)		Preeclampsia Gestational Diabetes
	Low Birth Weight (_ lbs)			Breast Fed
	Breech Birth				Poor suction/latch
	C-section Birth (planned)				Bottle Fed
	Emergency C-section				Multiple Ultrasounds
	Vaginal Birth				Oxygen at Birth
	Forceps Delivery				NICU Stay (Duration in NCIU:)
	Vacuum Delivery				Other:

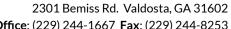


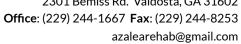
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Medical History

Please list any s	ignificant illnesses, hospitalizations, etc.:		
☐ Tubes☐ Tonsil☐ Reflux☐ Surge	ls/Adenoid Surgery x rries (list above) weight gain Sleep		Lyme Disease Abnormal Muscle Tone Torticollis Frequent Antibiotic Use Frequent Fevers Compromised Immune System Abnormal Lab Results Cardiac Issues Other:
Develop	omental History		
Fill in the blanks	s to describe your child to the best of your ab	ility.	
Sat at Crawled at Stood at Walked at Ran at Dressed at Toilet train Fed self at	months/years months/years months/years months/years months/years months/years months/years months/years	Put Mal	t single words at months/years words together at months/years king sentences at months/years months/years months/years
Please list any co	oncerns with feeding/eating or allergies.		
Please check all	descriptions that may apply to your child.		
☐ Enjoy ☐ Met a ☐ Is ath ☐ Is goo ☐ Is goo	placed on his/her belly as an infant ed belly time as an infant ill motor milestones on time letic/plays sports and negotiating playground equipment and with his/her hands (fine motorskills) not placed on his/her belly as an infant		Did not tolerate being placed on his/her belly as an infant Was late to: Was/is developmentally delayed Is clumsy Avoids climbing, swinging, sliding Gets overwhelmed in public places

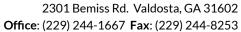






Speech & Language Goals & Development

What are your goals for therapy?		
What is your child's primary mode of communication? (Gestures, signing, s picture exchange. etc)	ingle words, short	phrases, sentences, augmentative device,
How does your child get his/ her needs met? (Pointing, grunting, taking iter	n to you, requesti	ng verbally, etc.)
Please give an estimate of how many words are in your child's vocabulary: Receptive (words understood): Expressive (words spoken):		
How much of your child's speech do you understand? 10% or less 11-24% 25-50% Are there any sounds your child has difficulty with? Please list:	<u> </u>	75-100%
How much of your child's speech do others understand? 10%orless 11-24% 25-50% Does your child demonstrate frustration when he/she is not understood? If	51-74% f yes, please expla	□ 75-100% in.
Is your child able to follow directions? (1 and 2 step?)		
Has your child's hearing been checked recently? Any concerns with hearing (ear infections, tubes, hearing aids, etc.)?	Yes/No	Results:
Has your child's vision been checked recently? Any concerns with vision?	Yes/No	Results:

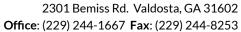


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Academic History

Nar	ne of school	Gra	Grade level Teacher
□ □ Plea	Does well in school Does well in the area of: Is challenged by school Average grades: ABCDF ase describe the services your child receives though the IEP or		Is in a self-contained classroom Has an IEP or 504 plan 4 plan, if applicable.
List	any specific teacher concerns:		
Plea	ase check all descriptions that may apply to your child.		
	Is social and engaging Makes good eye-contact with adults and peers Is well behaved Pays attention Listens well Follows directions well Plays well with other children Is easy going Does well with change Understands safety Takes turns with peers Recalls and tells about everyday events Maintains topic		Is oppositional Does not like newplaces/people Does not like crowds Has difficulty with transitions Prefers to play alone Has difficulty paying attention Has difficulty listening Is very busy and active Poor coping skills
Plea	ase list any behavioral or social concerns.		
Wh	at are some of your child's favorite toys/interests?		

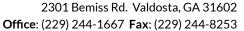




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Behavioral/Social Background

Please describe your child's living situation (and any recent changes).
Siblings names and ages:
Name / Age Name / Age
Name / Age Name / Age
If your child was adopted, please answer the following questions:
Age of adoption: Is your child aware of adoption? Yes/No
Please describe your child's personality.
How do you handle discipline issues at home?
Does you child have temper tantrums? Yes/No If yes, how often?
How does your child handle variations in routine?
How much screen time does your child get (i.e., tablets, smart phones, computers, TV, etc.)?
What games, toys, and activities does your child enjoy?
Describe how your child interacts with other children.
Describe your child's sleeping habits.
Describe a typical day for your family, especially this child.



AZALEA rehab services

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Authorization for Release of IEP from School System

Azalea Rehab Services 2301 Bemiss Rd., Valdosta, GA 31602 (229) 244-1667 FAX (229) 244-8253

Patient	Date
School System	
I,	hereby give my consent to 's Name School System
to release	current IEP to Azalea Rehab Services.
My child receives	therapy in school. Information is needed occupational/speech/physical
regarding school-re	elated therapy for current school year to
This authorization business at:	may be revoked at any time by delivering a signed Restriction Request Form to our
2301 Bemiss Rd.	
Valdosta, GA 3160	2
Signature of Patient, I	Parent or Guardian Date



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Cancellation/No Show Policy

For Evaluations & Therapy Appointments

1. Cancellation/No Show Policy for Evaluations and Therapy Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much-needed treatment.

Patients will be discharged from Azalea Rehab Services following (3) *No-Shows or (5) **Cancellations within a 2-month time period.

*A "no-show" is missing a scheduled appointment without prior notice

**A "cancellation" is removal of an appointment from our schedule after notifying Azalea Rehab Services at least 3 hours in advance.

2. Late Arrivals

We understand that delays can happen, however, we must try to keep the other patients and therapists on time. If a patient arrives 10 minutes past their scheduled time we will have to reschedule the appointment.

3. Account Balances

We require that Self-Pay patients bring their account balances to zero (0) every two (2) weeks prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to Heather Delaney to review their account and concerns.

Patients with balances over \$100 must arrange payment prior to future appointments being made.

Print Patient's Name	Print Parent's/Guardian's Name	
Patient/Parent/Guardian Signature	 Date	