AZALEA
rehab services

New Youth Patient Packet

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

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2301 Bemiss Rd. Valdosta, GA 31602
Office: (229) 244-1667 **Fax**: (229) 244-8253
azalearehab@gmail.com

New Patient Intake Form

Child's Legal Name | Child's Nickname | Date of Birth | M / F Gender

Primary Care/Pediatrician

Father or Legal Guardian

Father's DOB

Please check if it is ok to leave a message **Yes** **No**

Home Phone ☐ ☐

Cell Phone ☐ ☐

Work Phone ☐ ☐

Email

Physical Address

City, State, Zip

Occupation

Employer

Mother or Legal Guardian

Mother's DOB

Please check if it is ok to leave a message **Yes** **No**

Home Phone ☐ ☐

Cell Phone ☐ ☐

Work Phone ☐ ☐

Email

Physical Address

City, State, Zip

Occupation

Employer

:

If the primary person bringing the child to therapy is not listed above, please list their name and contact phone number.

Additional Authorized Contact Name _____ Phone

Is there a joint custody or parenting plan in effect?
____ Yes ____ No

Is there a restraining order in effect?
____ Yes ____ No

If "yes", against whom is the restraining order?
_____

INSURANCE INFORMATION (please complete all areas)

Primary Insurance

Policy Number

Group Number

Claims Address

Phone Number

Insured's Name

Insured's DOB

Secondary Insurance

Policy Number

Group Number

Claims Address

Phone Number

Insured's Name

Insured's DOB

Please initial the following statement:

_____ I **DO NOT** HAVE INSURANCE COVERAGE FROM ANY SOURCE OTHER THAN WHAT IS LISTED ABOVE.

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INSURANCE AUTHORIZATION
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 child while the premises of Azalea Rehab Services (ARS), we need your authorization to implement treatment. Please read and sign statement below.

As legal guardian of_____, I give my permission for Azalea Rehab Services tocontact emergency personnel in the event of a medical emergency.

Parent/Legal Guardian Signature **Date**

EMERGENCY CONTACT	
Name	Phone
Relationship	

MEDICATION/ALLERGIES/CONDITIONS
Medications (Include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

Allergies/Reactions:

Diagnoses (Any known medical diagnosis or medical condition, with dates of diagnosis if known):

PHOTO PERMISSION
Please **initial** the following OPTIONAL statements:

_____I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation.

_____I give permission for photos/video of my child to be used for advertising, brochure, and/or webspace.

TECHNOLOGY PERMISSION
Please **initial** the following OPTIONAL statements:

_____EMAIL: I give permission to Azalea Rehab Services to correspond with my child's legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that ARS e-mail is encrypted internally; however once an email is sent externally, correspondence may potentially be intercepted by an outside party.

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:
Please **initial** the following statements:

_____I hereby give Azalea Rehab Services permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and Azalea Rehab Services staff.

_____I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

Parent/Legal Guardian Signature **Date**

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General Background

Does your child ever complain of pain? If so, in what area? Please describe.

Please list any medical precautions/allergies/medications:

Is your child receiving any other services (i.e. Speech Therapy, Physical Therapy, Occupational Therapy, Special Education, Early Intervention)?

What (if any) special equipment does your child use?

- ☐ Wheelchair
- ☐ Eye Glasses
- ☐ Hearing Aids
- ☐ Braces
- ☐ Walker
- ☐ Crutches
- ☐ Communication Device
- ☐ Other:

Please list any other prenatal or birth history:

- ☐ Premature (Gestation: _____ weeks)
- ☐ Full Term
- ☐ Low Birth Weight (_____ lbs)
- ☐ Breech Birth
- ☐ C-section Birth (planned)
- ☐ Emergency C-section
- ☐ Vaginal Birth
- ☐ Forceps Delivery
- ☐ Vacuum Delivery
- ☐ Preeclampsia
- ☐ Gestational Diabetes
- ☐ Breast Fed
- ☐ Poor suction/latch
- ☐ Bottle Fed
- ☐ Multiple Ultrasounds
- ☐ Oxygen at Birth
- ☐ NICU Stay (Duration in NCIU: _____)
- ☐ Other: _____

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Medical History

Please list any significant illnesses, hospitalizations, etc.:

_____

_____

_____

- ☐ Chronic ear infections
- ☐ Tubes
- ☐ Tonsils/Adenoid Surgery
- ☐ Reflux
- ☐ Surgeries (list above)
- ☐ Poor weight gain
- ☐ Colic
- ☐ Poor Sleep
- ☐ Asthma
- ☐ Lyme Disease
- ☐ Abnormal Muscle Tone
- ☐ Torticollis
- ☐ Frequent Antibiotic Use
- ☐ Frequent Fevers
- ☐ Compromised Immune System
- ☐ Abnormal Lab Results
- ☐ Cardiac Issues
- ☐ Other:_____

Developmental History

Fill in the blanks to describe your child to the best of your ability.

Sat at _____ months/years
Crawled at _____ months/years
Stood at _____ months/years
Walked at _____ months/years
Ran at _____ months/years
Dressed at _____ months/years
Toilet trained at _____ months/years
Fed self at _____ months/years

First single words at _____ months/years
Put words together at _____ months/years
Making sentences at _____ months/years

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

_____

_____

Please list any concerns with feeding/eating or allergies.

_____

_____

Please check all descriptions that may apply to your child.

- ☐ Was placed on his/her belly as an infant
- ☐ Enjoyed belly time as an infant
- ☐ Met all motor milestones on time
- ☐ Is athletic/plays sports
- ☐ Is good negotiating playground equipment
- ☐ Is good with his/her hands (fine motor skills)
- ☐ Was 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

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Speech & Language Goals & Development

What are your goals for therapy?

What is your child's primary mode of communication? (Gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange. etc)

How does your child get his/ her needs met? (Pointing, grunting, taking item to you, requesting 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%orless ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

Are there any sounds your child has difficulty with? Please list:

How much of your child's speech do others understand?

☐ 10%orless ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

Does your child demonstrate frustration when he/she is not understood? If yes, please explain.

Is your child able to follow directions? (1 and 2 step?)

Has your child's hearing been checked recently? Yes/No Results:_____

Any concerns with hearing (ear infections, tubes, hearing aids, etc.)?

Has your child's vision been checked recently? Yes/No Results:_____

Any concerns with vision?

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Academic History

Name of school | Grade level | Teacher

- ☐ Does well in school
  Does well in the area of: _____
- ☐ Is challenged by school
  Average grades: **A B C D F**
- ☐ Is in a self-contained classroom
- ☐ Has an IEP or 504 plan

Please describe the services your child receives though the IEP or 504 plan, if applicable.

List any specific teacher concerns:

Please 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 aggressive
- ☐ Is oppositional
- ☐ Does not like new places/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
- ☐ Unable to self-calm
- ☐ Extremely sensitive to criticism
- ☐ Quickly escalates without apparent cause
- ☐ Has tantrums

Please list any behavioral or social concerns.

What 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.

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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 _____
Parent or Guardian's Name School System

to release _____ current IEP to Azalea Rehab Services.
Child's name

My child receives _____ therapy in school. Information is needed
occupational/speech/physical

regarding school-related therapy for current school year _____ to _____.

This authorization may be revoked at any time by delivering a signed Restriction Request Form to our business at:

2301 Bemiss Rd.
Valdosta, GA 31602

Signature of Patient, 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