St. Francisville Rehab Services

Physical Therapy Aquatic Therapy Occupational Therapy Speech Therapy

IF PATIENT IS UNDER 18 YEARS OF AGE A LEGAL GUARDIAN MUST SIGN ALL PAPER WORK

Name: _____ Date of Birth: _____ Age: _____
LAST FIRST M.I.

Gender: _____ Name & Relationship of Caregiver Present: _____

Number of people living in home: _____ Is your child currently receiving therapy at home or school? _____

Is there any known history of the following in the child's immediate or extended family?

- Autism
- Hearing Loss
- ADHD
- Learning Disability
- Speech/Language Delay
- Gross Motor Disorders

If yes to any of the above, please explain: _____

INSURANCE INFORMATION

Primary: _____ ID #: _____ Group #: _____

Secondary: _____ ID #: _____ Group #: _____

Policy Holder: _____ Relation: _____ DOB of Policy Holder: _____

REASON FOR VISIT:

Referring Physician: _____ Date of Next Visit: _____

Pediatrician: _____ Date of Last Visit: _____

Primary area of concern for your child? _____

_____

When did you first have concerns about your child? _____

What strategies or therapies have you previously tried? _____

What goals do you have for your child while in therapy? _____

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MEDICAL HISTORY:
(fill out the relevant sections for your child)

Was your child born prematurely? _____ If yes, how many weeks gestation? _____

Any complications during pregnancy/delivery? _____

Any medical problems detected at birth? _____

Has your child had any serious illness, injuries or hospitalizations? _____

Does your child have any medical diagnoses? If so, please list: _____

_____

Is your child currently taking any medications? If yes, please list: _____

HEARING STATUS

Does your child have a history of ear infections? _____ How many? _____ History of ear tubes? _____

When were tubes placed? _____ Does your child have a diagnosis of hearing loss? _____

Has your child had a recent hearing screening? If yes, what were the results? _____

FEEDING HISTORY

Does your child have any difficulty with feeding (choking with liquids, difficulty chewing solids, trouble with different textures, poor weight gain, reflux, etc)? _____

Is your child particularly selective about the foods he/she will eat? _____

SPEECH/LANGUAGE DEVELOPMENT

What is your child's primary mode of communication:
gestures, signs, single words, short phrases, sentences, augmentative picture exchange? (circle all that apply)

If your child is talking, what ages did they begin to: babble? _____ first word? _____ say 2-3 words? _____

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

_____ 10% or less _____11-24% _____25-50% _____51-74% _____75%-100%

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

_____ 10% or less _____11-24% _____25-50% _____51-74% _____75%-100%

COMMUNICATION HISTORY

Does your child appear frustrated when he/she is not understood? ____Yes ____No _____ Sometimes

Does your child repeat sounds or words when speaking? ____Yes ____No _____ Sometimes

Does your child socialize/play with other children? ____Yes ____No _____ Sometimes

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MEDICAL HISTORY, Part 2
(fill out the relevant sections for your child)

MOTOR DEVELOPMENT:

Please list the ages your child achieved the following milestones (leave blank if they have not yet achieved the skill)

- Rolled belly>back: _____
- Rolled back>belly: _____
- Sat independently: _____
- Crawled on hands/knees _____
- Cruised along furniture: _____
- Walked independently: _____

Does your child have problems with the following activities?

-Sitting:	YES / NO	-Catching Throwing:	YES / NO
-Crawling:	YES / NO	-Kicking:	YES / NO
-Walking:	YES / NO	-Riding a Bike:	YES / NO
-Jumping:	YES / NO	-Picking up small objects:	YES / NO
-Balance:	YES / NO	-Talking/Communicating Needs:	YES / NO

Does your child exhibit any of the following behavioral characteristics? (check all that apply)

___cooperative	___attentive	___restless	___withdrawn
___poor eye contact	___stubborn	___easily frustrated	___easily distracted
___separation difficulties	___destructive	___aggressive	___inappropriate behavior
___self-abusive behavior	___plays alone most of the time		___willing to try new things

FINE MOTOR SKILLS:

Is your child able to dress themselves? (Zip jackets? Tie shoes?) _____

Is your child able to feed themselves? (picking up finger food, using a spoon, etc) _____

Does your child have difficulty with handwriting? _____

Does your child have trouble using scissors? Markers/crayons? _____

Is there any other info not included on this form that may be helpful for the therapist to know about your child and his/her condition? _____

_____

_____

WEST FELICIANA PARISH HOSPITAL
ST. FRANCISVILLE, LOUISIANA

CONDITIONS OF ADMISSION AND/OR TREATMENT

1. **GENERAL DUTY NURSING**: The hospital provides only general duty nursing care. Under this system, nurses are called to the bedside of the patient by a signal system. If the patient is in such a condition as to need continuous or special duty nursing care, it is agreed that such must be arranged by the patient, or his legal representative, or his physicians, and the hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact said patient is not provided with such additional care.

2. **MEDICAL AND SURGICAL CONSENT**: The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians. The undersigned consents to any x-ray examination, laboratory procedure, anesthesia, medical or surgical treatment, tests for diagnostic research, or scientific purposes and any other hospital service rendered to the patient under the general and special instructions of the physicians. The undersigned recognizes that all doctors of medicine furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, and the like, are independent contractors and are not employess or agents of the hospital.

3. **PERSONAL VALUABLES**: It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage of any money, jewelry, documents, furs, fur coats, and fur garments or other articles of unsual value and small compass, unless placed therin, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safe-keeping. Valuables may be retrieved only during normal business office hours.

4. **RELEASE OF INFORMATION**: The hospital may disclose all or any part of the patient's record to any person or corporation which is or maybe liable under a contract to the hospital or to the patient, or to a family member or employer of the patient for all or part of the hospital's charge, including but not limited to, hospital or medical service companies, insurance companies, and worker's compensation carriers.

5. **ASSIGNMENT OF INSURANCE BENEFITS**: In the event the undersigned is entitled to hospital benefits of any type whatsoever arising out of any policy of insurance, insuring the patient or any party liable to the patient, said benefits are hereby assigned to West Feliciana Parish Hospital for application to the patient's bill, and it is agreed that West Feliciana Parish Hospital may receipt for any such payment and such payment , the undersigned and/or patient being responsible for all charges not covered by this agreement. The undersigned hereby assigns all benefits due them, to individual hospital contractors, such as the pathologist, anesthesiologist, radiologist and emergency room physician.

6. **STATEMENT OF PERMIT PAYMENT OF HOSPITAL AND MEDICAL INSURANCE BENEFITS TO HOSPITAL** (where applicable): The undersigned patient hereby certifies that the information given him in applying for payment under the titles XVIII and XIX of the Social Security Act is correct and the hospital is authorized to release any information needed to act on this request. The undersigned patient also hereby request that payment of authorized benefits be made in his behalf and hereby assigns to West Feliciana Parish Hospital. The patient understands that he is responsible for any health insurance deductibles and the uninsured percentage of the remaining reasonable charges.

7. **FINANCIAL AGREEMENT**: The undersigned agrees, where he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of West Feliciana Parish Hospital within five (5) days of the rendering of the final bill unless a verified form of third party reimbursement has been presented to and accepted by the Hospital. If the third party does not pay within 30 days, the bill becomes the obligation of the patient or Guarantor. Until such time as the account is paid in full the hospital, its attorney, and/or collection agency may:
   A. Utilize the resources of a consumer credit reporting bureau;
   B. Contact the patient or patient's agent in writing or by telephone while in the hospital and residence during normal hours to discuss or request payment of the account and;
   C. Contact the patient's employer for the purpose of employment verification. Should the account be referred to a collection agency and/or attorney for collection, the undersigned should pay all court costs and attorney fees. A service charge in the amount of 1 ½ % (one and one-half percent – 18% per annum) on the unpaid balance or $0.50/month, whichever is more, will apply to this account on balances remaining unpaid after 90 days following the date of discharge.

8. **X-RAYS:** X-rays will be initially reviewed by Emergency Physician or your private doctor. They will be referred to a radiologist for immediate interpretation, or will be read by the radiologist the following day for a final interpretation. Federal regulations require fees charged by radiologists be billed separately from your hospital charges. Therefore, you will receive a bill from our radiologist.

9. Individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, color, creed, sex, national origin, age, handicap, or source of payment for care.

10. **AUTHORIZATION FOR TREATMENT**: The undersigned has been informed of the treatment considered necessary for the patient whose name appears below and that the treatment and procedures will be performed by physicians, members of the house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures.

    The undersigned understands that a personal physician is to be selected by or on behalf of the patient within 24 hours if hospitalization or further treatment is required, or immediately if complications arise. YOU HAVE THE RIGHT TO SELECT your personal physician for hospital care. If he or she is on the active staff of this hospital or to choose from a list of those doctors who treat patients at this hospital.

    The undersigned has read the authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.

DATE: _____ TIME: _____ PATIENT: _____

_____ _____

WITNESS PATIENT'S AGENT/REPRESENTATIVE

_____

RELATIONSHIP TO PATIENT

PATIENT FINANCIAL RESPONSIBILITY POLICY

INSURANCE OR ADDRESS CHANGE

- A current insurance card and ID must be presented at registration.
- It is important that we have your correct information on file at all times. Please advise us of any change to your insurance carrier, address, telephone number, or other contact information.

INSURANCE

- As a courtesy to you, West Feliciana Hospital will bill your insurance company directly for medical services rendered at St. Francisville Rehab Services. However, please be advised that **YOU are ultimately financially responsible for payment of medical services rendered on your behalf**.
- It is important for you to be an informed consumer who understands the specifications of your insurance policy. Your health insurance policy is a contract between **you** and **your health insurance provider and/or employer**. If you are uncertain about your policy benefits you should contact your plan to learn about your benefit details, financial responsibility, coverage limits, and referral/authorization requirements.
- If we contact your insurance provider regarding benefits or authorizations on your behalf, we are not responsible for inaccurate information provided to us by your carrier.

REFERRALS AND AUTHORIZATIONS

- Please be aware of and provide any required referrals or authorizations that may be required by your carrier before therapy begins. If these are not provided by either yourself, referring physician or insurance carrier before care is provided, you will be responsible for the cost of the services rendered. When in doubt, contact your plan directly.
- Some of the carriers requiring an authorization before therapy services can begin are listed below but are not limited to:
    - Workers Compensation
    - People's Health
    - Vantage
    - Blue Advantage
    - Web TPA

MEDICAID

- All Medicaid therapy services require an authorization for treatment once the evaluation has been performed. Our office will obtain that authorization for you.
- These authorizations are comprised of both a visit amount and specific date range that therapy must be completed in. This means that it is important for consistent attendance.
- **PLEASE NOTE: If your Medicaid coverage changes and you do not notify our office in a timely and prompt manner, we will be unable to obtain the required authorization. This will result in Medicaid's denial of payment and the financial responsibility will then revert to the patient.**

THERAPY RESULTING FROM MOTOR VEHICLE ACCIDENTS

- If you are receiving therapy due to a motor vehicle accident, it is a hospital billing policy that your account will be set up with HMG (WFPH's law firm), as well as your personal medical coverage/attorney representation (if provided).
- **PLEASE NOTE**: Some Health Plans will not pay on therapy due to accident related injuries.
- Printed Name of Patient

Printed Name of Patient: _____ Date: _____

Signature of Patient or Legal Guardian: _____

ST. FRANCISVILLE REHAB SERVICES

By signature below, I acknowledge that I have received the Notice of Privacy Practices for St. Francis Rehabilitation Services.

If the patient is unable to sign this acknowledgement the patient representative may sign as the receiving person

Patient's name: (Please print) _____

Signature: _____
(Patient or Representative)

Date: _____

If for any reason a signature from the patient or their representative cannot be obtained, reasons must be documented below:

_____

_____

_____

_____

_____

Staff member signature: _____

Date: _____

Appointment Reminder Option

We provide convenient appointment reminders as an additional service to you. Please complete the information below to give us permission to provide you with automatic appointment reminders via cell phone text message. You may decline this service below or change your permissions at any time.

Please select **one** of the following options:

☐ **Text Messages:** I authorize St. Francisville Rehabilitation Services to send automated texts messages regarding my rehab appointments to this cell phone number: (_____) _____.

Standard messaging rates may apply.

☐ **No Reminder:** I choose to opt out of the reminder call service sending text messages to my cell phone regarding my rehab appointments.

Patient Name: _____

Patient Signature: _____

(Parent/Guardian signature if minor)

ST. FRANCISVILLE REHAB SERVICES

ATTENDANCE POLICY

Once an evaluation is completed and a plan of care has been established, the patient (or guardian) is responsible for making and keeping appointments.

In the event that you are unable to attend your scheduled appointment, every attempt should be made to contact the office **PRIOR** to your appointment time, in order to reschedule.

If appointments are not cancelled, and a "no call, no show" occurs on 3 occasions, the patient will be discharged from therapy services and another evaluation will not be performed for a minimum of 3 months.

Thank you for understanding.

Patient/Guardian Signature: _____