Active Development Therapies, LLC

Medication Form

Patient Name:________________________________ Physician Name:________________
Allergies:________________________________ Physician Phone:________________
Pharmacy #:________________________________ Physician Fax # :________________

Date	Drug Name	Dosage	Frequency	Route	Status	D/C Date
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	
			☐QD ☐QID ☐BID ☐___ ☐TID ☐___	☐PO ☐GT ☐IV	☐New ☐Change	

Therapist Signature Date Therapist Signature Date

PtID# ____________________ Medicaid#________________________

Active Development Therapies, LLC

Medical History Questionnaire

Your time and assistance in completing this form is appreciated. This form is to allow us to gather as much pertinent information for your child's evaluation and implementation of therapy services. Please complete all sections to the best of your ability.

Child's full legal name:_____ Nickname:_____

Date of Birth: _____ Age: _____

FAMILY HISTORY

Father's Name:_____ Mother's Name:_____

Child lives with:

- ☐ Natural father and mother
- ☐ Natural mother only
- ☐ Natural father only
- ☐ Natural mother and step-father
- ☐ Natural father and step-mother
- ☐ Other _____
- ☐ Grandparent(s) Maternal Paternal
- ☐ Adoptive Parents at age _____
- ☐ Foster Parents since _____
- ☐ Legal Guardians
- ☐ Siblings _____

What language is spoken in the home? _____

What language does your child understand best?_____ Speak best?_____

BIRTH/MEDICAL HISTORY

Problems present during pregnancy:

- ☐ Measles
- ☐ high blood pressure(pre-eclampsia)
- ☐ alcohol/drug use
- ☐ toxemia
- ☐ medications
- ☐ smoking
- ☐ seizures
- ☐ Other _____
- ☐ gallbladder
- ☐ diabetes

Type of delivery:

- ☐ short labor
- ☐ labor induced
- ☐ Prematurity ____wks. early
- ☐ long labor
- ☐ non-progressive labor
- ☐ _____At term
- ☐ c-section
- ☐ other _____
- ☐ forceps/vacuum
- _____wks late

Any other problems related to your child's birth not mentioned above_____

_____

_____

Duration of Child's hospital stay after birth: _____

Check whether your child presently or previously has any of the following illnesses or conditions:

- ☐ Shunt placement
- ☐ Reflux
- ☐ RSV
- ☐ Aspiration
- ☐ Seizures Date of last seizure_____
- ☐ Chronic ear infections ☐ PE Tubes R L
- ☐ Tonsillitis
- ☐ Allergies _____

Is your child currently on any medications? If yes, please list. _____

_____

Any other serious illnesses, accidents, surgeries, chronic or frequent physical/medical problems your child has had which are significant: _____

_____

_____

PtID#_____ Medicaid#_____

Hearing/auditory and Visual functioning: Does your child have

- ☐ trouble hearing/understanding what is said
- ☐ frequent need for instructions to be repeated
- ☐ cochlear implant
- ☐ nearsightedness ☐ farsightedness
- ☐ homonymous hemianopsia R L
- ☐ other _____
- ☐ mild hearing loss
- ☐ suspected/diagnosed deafness
- ☐ hearing aids
- ☐ suspected/diagnosed blindness
- ☐ cortical blindness

When was your child's hearing last tested?_____By whom?_____Results_____
When was your child's vision last tested?_____By whom?_____Results_____

Please list the doctors who have cared for your child

Name:_____ Name:_____

City:_____ City:_____

Date last seen:_____ Date last seen:_____

Specialty:_____ Specialty:_____

DEVELOPMENTAL/THERAPY HISTORY

Has your child received prior therapy services? OT PT ST Counseling

☐ ECI ☐ School District ☐ Private Practice ☐ Home Health ☐ Hospital

When were services rendered and/or discharged? Why?_____

_____

EMOTIONAL/SOCIAL HISTORY

Do you feel your child exhibits any unusual behaviors? ☐ Yes ☐ No

If yes, please explain:_____

_____

Does your child keep to him/herself or prefer to interact freely with other children?

Please explain:_____

_____

The following words best describe my child at home

- ☐ cooperative
- ☐ attention seeking
- ☐ considerate of others
- ☐ nervous
- ☐ uses immature speech
- ☐ other_____
- ☐ self confident
- ☐ easily upset
- ☐ a leader
- ☐ self-centered
- ☐ easily frustrated
- ☐ withdrawn
- ☐ violent
- ☐ a follower
- ☐ untruthful
- ☐ difficulty expressing self
- ☐ shy
- ☐ moody
- ☐ independent
- ☐ self-destructive

Has your child received services from a social/mental health facility? ☐ Yes ☐ No

If yes, explain reasons why and where?_____

_____

EDUCATIONAL HISTORY

School/Daycare attends_____ # days/wk_____ # hours/daily_____

Has your child repeated a grade in school? ☐ Yes ☐ No If yes, list grade/reason_____

What are the main concerns you would like addressed?_____

_____

_____

Information provided by:_____ Date_____

Relation to child:_____

PtID#_____ Medicaid#_____

Active Development Therapies

Consent for Treatment

Patient Name:_____ DOB: _____

Consent for Treatment: I consent to have Active Development Therapies, L.L.C. provide therapy services according to the clinic's policies and procedures. It is understood that these services will be performed as ordered by the referring physician and the recommendations from the appropriate evaluating therapist. Services provided by Active Development Therapies, L.L.C. may include: Physical, Occupational, and Speech Therapy. All services provided by Active Development Therapies, L.L.C. will be supervised by clinic administration according to this company's policies and procedures, along with any state and federal regulations.

Medical Records Transfer and Release Procedure: Medical records will be released in accordance with current HIPPA privacy regulations in the form of a summary or copy, except when forbidden by law. In order to transfer medical records to third party payers, patients and/or other health care providers, the following procedure will be implemented:

1. Transfer of the patient's clinical records as indicated above and any other information will be allowed after the patient/legal guardian has signed an authorization for release of records.
2. Medical records subpoenaed by the court: Medical records will be released through a legal court subpoena, and the Director of Habilitation shall compile any information subpoenaed.

I consent to abide by the facility's specific policies and procedures relating to therapy services and protection of patient's privacy rights as regulated by HIPPA.

Assignment of Insurance: I hereby consent to allow Active Development Therapies, L.L.C. to bill and collect all of my right, title and interest in, and to any and all insurance benefits otherwise payable to me by any and all of my insurance carriers but not to exceed the balance due of the Facility's usual charges for this period of therapy services. I understand and agree that I am financially responsible to the facility for charges not covered by insurance benefits or for any co-pays or deductible payments and to be paid to the facility as stated in this agreement.

Patient Liability for Payment: As the patient you have the right to be advised before therapy begins about any costs which may not be paid by Medicare, Medicaid or other insurance companies, and the extent to which payment may be required from you. We are advising you orally and in writing, about the cost to you of services to be provided as listed below:

___ **MEDICARE:** Your insurance covers _____% of the allowed charges. You are responsible for _____ co-pay per visit, which is the amount your insurance does not cover. The deductible amount of $_____ will be billed to you.

___**MEDICAID:** Services provided are paid in full by Medicaid #_____. As the patient, you will be notified of any change in the charges to you for your therapy services provided through Medicaid, or relevant Federal programs as soon as possible, but no later than 30 working days from the date that Active Development Therapies, L.L.C. becomes aware of the change.

___**Private Insurance:** Your insurance covers _____% of the charges. You are responsible for _____ co-pay per visit, which is the amount your insurance does not cover. The deductible amount of $_____ will be billed to you.

___**Private Pay:** You are responsible for charges related to the services provided to you by this facility. Charges are as follows: $_____ per evaluation, and $_____ per visit.

Patient's Certification: I certify that the information given by me is true and correct. I agree to notify Active Development Therapies, L.L.C. immediately if there are any changes in my Medicare, Medicaid or Insurance status.

THE UNDERSIGNED CERTIFIES THAT HE/SHE UNDERSTANDS THE ABOVE INFORMATION, THAT HE/SHE IS THE PATIENT, LEGAL GUARDIAN, AND/OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

_____ _____ _____

Patient or Authorized Representative Witness Date

Active Development Therapies

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Patient Rights:

1. Exercise your rights as a patient of Active Development Therapies, L.L.C. (ADT)
2. A family member or a guardian exercising your rights if you have been judged incompetent.
3. Have your property treated with respect.
4. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of Active Development Therapies, L.L.C. and will not be discriminated against for doing so.
5. Active Development Therapies, L.L.C. investigating you or your families complaints and we will document both the existence of the complaint and the resolution of the complaint.
6. Be advised by Active Development Therapies, L.L.C. in advance regarding which discipline will furnish services and the frequency of the visits proposed after the initial evaluations.
7. To participate in the planning of the treatment and changes in the treatment plan.
8. Be informed in advance about the plan of care to be furnished and of any changes in the plan of care before the change is made.
9. Confidentiality of your clinical record maintained by this facility.
10. Be informed orally or in writing, by Active Development Therapies, L.L.C. before treatment is initiated
    a. The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the facility.
    b. The charges for services not covered by Medicare, Medicaid, or Private Insurance.
    c. The charges you are responsible to pay.
11. Be informed orally or in writing by Active Development Therapies, L.L.C. of any changes in these charges, as soon as possible but no later than 30 working days from the date Active Development Therapies, L.L.C. becomes aware of the changes.
12. Be informed orally or in writing by Active Development Therapies, L.L.C. of our Notice of Privacy Practices, requirement to report "Client Abuse, Neglect, or Exploitation", and Section 504 Notices.

Patient Responsibilities:

1. Give accurate and complete health information concerning your past medical history and other pertinent information.
2. Comply with ADT policies and procedures regarding: patient compliance, communicable diseases, accessing treatment areas, video, audio or picture taking, and patient, parent, visitor conduct.
3. Assist in the development of and updating of your plan of care.
4. Follow your home care plan.
5. Inform the facility of any changes in your health status that may affect your care.
6. Request further information /assistance concerning anything you do not understand.

Advance Directives: Some patients make arrangements in advance requesting that they do not be resuscitated in the event of an emergency. An Advance Directive may be made to prevent medical personnel from using all means to extend life.

_____I do **not** want information on Advance Directives.

_____I would **like** more information on Advance Directives.

_____An Advance Directive already exist and we will provide Active Development Therapies, L.L.C. with a copy and Active Development Therapies, L.L.C. will abide by it.

Customer Concerns and Complaints Procedure:

1. File a written complaint with the Director of Habilitation

2. Direct complaints against the facility to the following agencies:

a. For Outpatient services: Texas Department of Health & Human Services, Complaint & Incident Intake at: Compliant Hotline:1-800-458-9858 option 5; Email: hfc.complaints@hhs.texas.gov; Fax: 883-709-5735; Mail: Code E-249 P.O. Box 149030 Austin, TX 78714-9030

b. For Physical and Occupational Therapy Services, Contact Texas Board of Physical and Occupational Therapy Examiners Call: 1-800-821-3205 (complaints only) or 512-305-6900 or Visit: www.ptot.texas.gov or Mail: 1801 Congress Ave Ste 10.900 Austin, TX 78701

c. For Speech Therapy Services, Contact Texas Department of Licensing and Regulation by going to: https://www.tdlr.texas.gov/complaints/default_Licensed.aspx

I HAVE REVIEWED AND UNDERSTAND MY BILL OF RIGHTS AND RESPONSIBILITIES DESCRIBED ABOVE AS WELL AS THE CUSTOMER CONCERNS AND COMPLAINTS PROCEDURE.

_____	_____	_____
Patient's Name	Parent/Legal Guardian Signature	Date

Medicaid #: _____ Patient ID #: _____

Active Development Therapies, LLC

Patient Compliance Agreement

Patient attendance and patient/family member involvement and compliance with the patient's therapy session(s), plan of care, and home exercise program are necessary for the patient to receive the maximum benefit from physical, occupational, and/or speech therapy services.

In the event of a LATE ARRIVAL, I understand that:

1. I must notify the facility if will be late for scheduled appointment time,
2. If the patient arrives more than 30 minutes late the appointment may be rescheduled ____ INITIALS

To prevent a LATE PICK-UP of the patient from their therapy appointment, I understand that I must:

1. Arrive back at the clinic at least 20 minutes prior to the end of the final appointment,
2. Not leave the premises if there is only 30 minutes until the end of the final appointment
3. Not leave the premises if the scheduled appointment is only 30 minutes in length ____ INITIALS

In the event of MISSED VISITS, I understand that if the patient:

1. CANCELs an appointment, it must be cancelled as soon as discovering the need to miss and an attempt will be made to reschedule it
2. NO SHOWs (misses without notification) and/or DOES NOT meet 80% attendance compliance for an entire month, are subject to Non-Compliance consequences ____ INITIALS

If a patient is placed ON-HOLD, I understand that:

1. On-Hold status is for a maximum of 30 days
2. If the patient is unable to return to therapy after 60 days On-Hold they will be discharged ____ INITIALS

TRANSPORTATION is important in order to get the patient to their therapy appointments; however, being escorted by an authorized adult is important to maintain patient safety during the travel to and from the clinic. I agree that if the patient is 14 years or younger they will be accompanied by an authorized adult, whether they are driven directly or provided medical transportation. ____ INITIALS

Failure to comply with these policies will lead to Non-Compliance consequences set forth in the Patient Compliance Policy. The potential consequences vary dependent on the situation at hand, please notify a staff member if you have any questions prior to signing this acknowledgement.

I acknowledge that it is my responsibility to comply with Active Development Therapies Patient Compliance Policy and that I have received a copy of the policy and signed agreement.

GUARDIAN SIGNATURE _____ PRINTED NAME _____ DATE _____

PATIENT NAME _____ PATIENT ID _____ PATIENT MC# _____

Active Development Therapies, LLC

REQUEST FOR RELEASE OF PRIOR AUTHORIZATION NUMBER

Client Name:	Medicaid Number:
_____	_____

To Whom It May Concern:

I would like to request the release of my child's current Authorization Number as to change service providers from _____ to Active Development Therapies, LLC.
(Entity or Provider)

The last date of service from _____ will be on _____. The effective date for **Active Development Therapies, LLC** is to begin on or after _____.
(Previous Entity or Provider)

The reason for the change of provider is:_____

_____

_____

_____

Sincerely,

_____
Signature of Parent or Legal Guardian

_____
Printed Name of Parent or Legal Guardian

PtID:_____ Medicaid#_____

For the Office of:

Active Development Therapies

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____

Active Development Therapies, LLC

Communicable Disease Agreement

It is the policy of Active Development Therapies; LLC that in the event your child becomes ill, the clinic will utilize the following guidelines to begin treating your child again as listed below. (Note: if you, as the parent, are unsure of your child's condition, please do not hesitate to call and receive guidance as to the action you should take. Also, if you or your child is in an emergency situation, please call 9-1-1)

Cancel appointment if one or more of these conditions are present:

- Oral temperature of 100 degrees or above
- Vomiting, nausea or severe abdominal pain
- Diarrhea: runny, watery or bloody
- Sore throat, acute cold, or persistent cough
- Swollen glands around jaws, ears, &/or neck
- Earache
- Red, inflamed, or discharging eyes
- Acute skin rashes or open sores, including but not limited to bacterial lesions, scabies, any weeping sores
- Head Lice
- Other symptoms suggestive of acute illness

Required Return to Therapy Guidelines:

- Fever free for at least 24 hours
- Symptom free of vomiting, nausea, or severe abdominal pain for at least 24 hours
- Symptom free of diarrhea: runny, watery, or bloody for at least 24 hours
- Symptom free of sore throat, acute cold, persistent cough for at least 24 hours
- Treated Head Lice
- All health conditions listed above have been treated and resolved OR are fever/symptom free for at least 24 hours
- Doctor's order stating patient can return to therapy or is not contagious

I agree to call to inform facility staff of need to cancel and attempt to reschedule the visit.

_____
Patient Name

_____ _____
Parent/ Guardian Signature Date

PtID#_____ Medicaid#_____

Policy and Procedures on Patient, Parent/Caregiver, and Visitor Conduct

Active Development Therapies, LLC

Date: March 22, 2013

Authority: Director of Habilitation

Responsibility: All Full-Time and Part-Time employees

Purpose: To ensure that established policies and procedures are followed in order to maintain the safety of Active Development Therapies' patients, patient's families, visitors, and employees on the facility premises during business hours.

Policy: It is our policy that the patient, his/her family, and any visitor are compliant with the following procedures to ensure that each client's and ADT employee's safety is protected while on Active Development Therapies, LLC premises.

Procedures:
The following procedures should be followed when a patient and their family/caregiver and/or visitor is present on Active Development Therapies, LLC premises.

1. Park in Designated parking spots
2. Accompany your child/family member into the clinic waiting room
3. Sign in for all appointments and wait for treating therapist to greet you
4. Come into clinic waiting room to pick up your child/family member from the treating therapist
5. Be respectful of others
6. No Soliciting of any kind while on premises
7. No Profanity or vulgar language
8. No Lewd behavior
9. No Smoking in the building or within 25 feet of entries
10. No Consumption of Alcoholic beverages or other illegal substances

The following disciplinary action will be taken when anyone does not follow the above stated procedures:

First Offense:	Verbal Warning by a Facility Director
Second Offense:	Facility Director Will contact appropriate Authority i.e. Montgomery County Sheriff's Department and/or Child/Adult Protective Services
Third Offense:	Right for Active Development Therapies, LLC to terminate the patient's services

GUARDIAN SIGNATURE _____ PRINTED NAME _____ DATE _____

PATIENT NAME _____ PATIENT ID _____ PATIENT MC# _____

Active Development Therapies, LLC

23750 FM 1314 Rd.
Porter, TX 77365
Phone: (281) 354-3383 Fax: (281) 354-6750

To Whom It May Concern:

I give my permission for Active Development Therapies, LLC to record, videotape and/or photograph my son/daughter,_____ and use those images for assessment and/or treatment purposes within our therapy practice.

_____
Printed Name (Parent/Legal Guardian)

_____ _____
Signature (Parent/ Legal Guardian) Date

PtID#_____ Medicaid#_____