# Helling Children's Center, L.P.

12605 East Freeway, Suite 212 Houston, Texas 77015
Tel. (713)453-0400 Fax (713) 453-0408

## Contact Information

| Date | | Child's Full Name | |
|---|---|---|---|
| Date of Birth | | Age | |
| School | | Teacher | Grade |
| Physician | | Physician's Phone Number | |
| Physician's Address | | Physician's City/State/Zip Code | |
| How did you find out about our service? | | | |

| Mother's Name | | Father's Name | |
|---|---|---|---|
| Home Address | | Home Address | |
| Home City/State/Zip Code | | Home City/State/Zip Code | |
| Home Phone | Work Phone | Home Phone | Work Phone |
| Occupation | | Occupation | |
| Business Name | | Business Name | |
| Business Address | | Business Address | |
| Business City/State/Zip Code | | Business City/State/Zip Code | |

| **EMERGENCY CONTACT** | |
|---|---|
| Emergency Contact Name (person not living with child) | Relationship to child |
| Home Phone | Work Phone |
| Home Address | Home City/State/Zip Code |

**Parent/Legal Guardian Signature** **Date** **Witness Signature** **Date**

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## Child/Family History

**General Information**

Child's Name: ________________________________________ Date of Birth: ____________ Age: ________
Address: _____________________________________________ City: __________________ Zip: _________

Home phone #: ______________Cell phone #: ______________Work phone #: ______________

**Family**

1) Whom does child live with? □ Mother □ Father □ Grandparent's
□ Guardian □ Other (name/relation) _______________________________

Parent's/Guardian's Name___________________ Parent's/Guardian's Name___________________

2) Please write the names and ages of all brothers and sisters:

| Name | Age | Name | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

3) With whom does the child spend most of his/her day? ___________________________________________

4) What language(s) does the child speak? ___________________________

5) What language(s) are spoken in the house? ________________________

6) Describe the child's problem. ______________________________________________________________

_____________________________________________________________________________________

7) When was the problem first noticed? _________________________________________________________

8) By Whom? __________________________________

9) Is there anyone in your family with a similar problem? ________________________________________

**Pre-natal and Birth history:**

10) Mother's general health during pregnancy: ________________________________________________

Illness _________________ Accident(s) __________________ Medication(s) __________________

Other Comments: _____________________________________________________________________

11) Baby's birth weight __________________ Born at _________months

12) Type of delivery (please check):
□ Head first □ Caesarian:
□ Feet first: □ Other: _____________________________________________________

13) Did the baby have any respiratory or feeding difficulties? □ Yes □ No

If yes, please explain: ________________________________________________________________

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Child's Name: ___________________________

**Developmental History:**

14) Provide the approximate age at which the child began to do the following activities independently: If not independent, in these categories, please write in how much help you give your child in these areas (for example, 25%, 50%, 75%, or 100%).

Crawling _______ Sitting _______ Standing _______ Walking _______
First words _______ Dressing _______ Toileting_______

Other Comments: ___________________________________________________________________

___________________________________________________________________________________

15) Has your child received Early Childhood Intervention (ECI) services? □ Yes □ No

If yes, please list the ECI provider and ECI services your child received: ___________________________

___________________________________________________________________________________

**Medical History:**

16) Date of last physical exam by a pediatrician/primary care physician: _____________________________

17) What were their conclusions or suggestions? (Please describe) ___________________________________

___________________________________________________________________________________

18) List any items that cause your child to have an allergic reaction, e.g., food, grass, latex, or medications?

___________________________________________________________________________________

**19) Please check if your child has/had any of the following conditions and the approximate age of onset:**

| | (At what age?) | | (At what age?) | | (At what age?) |
|---|---|---|---|---|---|
| □ Allergies | __________ | □ Dizziness | __________ | □ High fever | __________ |
| □ Asthma | __________ | □ Draining ear | __________ | □ Meningitis | __________ |
| □ Chicken Pox | __________ | □ Ear infections | __________ | □ Pneumonia | __________ |
| □ Colds | __________ | □ Encephalitis | __________ | □ Sinusitis | __________ |
| □ Convulsions | __________ | □ Headaches | __________ | □ Other | _______________ |
| □ Croup | __________ | □ Head injuries | __________ | | |

20) Has your child had any hospitalizations? □ Yes □ No
If yes, when and why: _____________________________________________________________

21) Is the child taking any medications? □ Yes □ No
If so, what medications? ___________________________________________________________

22) Has your child seen any specialists? □ Yes □ No
Whom/When? ____________________________________________________________________

___________________________________________________________________________________

23) What were their conclusions or suggestions? (Please describe) ___________________________________

___________________________________________________________________________________

___________________________________________________________________________________

24) Has the child had any surgeries? □ Yes □ No
What type and when? ______________________________________________________________

___________________________________________________________________________________

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Child's Name: ___________________________

25) Date of last hearing test completed: ___________ Results: □ Normal □ Other______________________

26) Date of last vision test completed: _____________Results: □ Normal □ Other______________________

**Academic History:**

27) If your child is not attending school yet, where does he/she stay during the day?

_____________________________________________________________________________________

28) If your child is attending school please complete the following questions:
School Name: ________________________________________
Grade: _________________ Teacher's Name: __________________________

29) Type of classroom your child is in: □ Regular □ Speech
□ Special education (e.g. PPCD, Resource, Life Skills)

30) Has an IEP plan been developed? □ Yes □ No

31) How is the child doing academically? ___________________________________________________________

32) Does the child receive any modifications, therapy, or special assistance in the classroom? □ Yes □ No
If the answer is yes, please describe: _________________________________________________________

33) Type of services/therapy ________________ Provider's Name ___________________Times a week _____
Type of services/therapy ________________ Provider's Name ___________________Times a week _____
Type of services/therapy ________________ Provider's Name ___________________Times a week _____

**Behavior:**

34) How does your child interact with other children?
□ plays with others □ tends to sit away from others □ often cries
□ aggressive toward others □ screams at others □ fights with others

Other Comments: _____________________________________________________________________

_____________________________________________________________________________________

35) Please check if your child has problems/ difficulties with any of the following:
□ eating □ sleeping □ seeing □ hearing □ behavior □ speech

Describe the child's problem. _________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

36) Has he/she ever had tantrums? □ Yes □ No At what age? _______

Describe the child's tantrums. ________________________________________________________

_____________________________________________________________________________________

37) Who disciplines your child at home? □ Mother □ Father □ Grandparent's
□ Guardian □ Other (name/relation) _____________________

38) What type of discipline is used at home with your child? ___________________________________________

_____________________________________________________________________________________

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Child's Name: ____________________________

**Communication:**

39) How does the child usually communicate? □ gestures □ single words □ pointing □ sentences □ sign language □ picture symbols □ other ________________________

40) Can he/she answer yes/no questions appropriately? □ Yes □ No

41) Can the child follow simple directions like "wash your hands" or "close the door"? □ Yes □ No

42) Does he/she engage in conversation? □ Yes □ No

43) Has anyone in the family ever had any of the following problems?
□ speech □ hearing □ language □ swallowing □ learning
□ stuttering □ other _______________________________

44) Can your child:
- Combine words (e.g. me go, daddy shoe, etc.) □ Yes □ No
- Use single words (e.g. no, doggie, mom) □ Yes □ No
- Name simple objects (e.g. dog, car, tree) □ Yes □ No
- Use simple questions (e.g. where is the dog?) □ Yes □ No

45) Check any of the feeding problems your child has or has had in the past:
□ chewing □ drooling □ gagging
□ sucking □ swallowing □ other feeding problems: _____________________

46) Please check if your child has difficulty with:
□ walking □ running □ participating in activities, which require coordination

47) How does your child respond to loud sounds?
□ does not always hear sounds □ cries at loud noise □ startles easily
□ covers ears at loud sounds □ turns toward loud sounds

Other Comments: ___________________________________________________________________

_______________________________________________________________________________

48) Please check all the items your child has difficulty with:
□ buttons □ markers □ zippers
□ opening containers □ shoe laces □ having hands dirty

Other Comments: ___________________________________________________________________

_______________________________________________________________________________

**Parent(s) Comments:**

49) What are your personal goals for this evaluation and for therapy if your child requires it? What skills would you like your child to learn? Please list at **least 3 specific tasks or skills related to his/her problems:**

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________ ____________________________

Signature of Person Completing Form Date Relationship to Child

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Child's Name: ___________________________

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## Comprehensive Treatment Plan Agreement

The following is a description of this center's policies regarding the comprehensive treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies please ask a representative of this center before signing.

**Non Discrimination Policy**
Helling Children's Center, LP does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information contact the Front Office Supervisor or TTY State Relay at 1 800 735-2988.

Speech, Hearing and Visual assistance communication guides are available at no charge and upon request. For further information contact the Front Office Supervisor or TTY State Relay at 1 800 735-2988.

*Initials*__________

**Scheduling Policy and Consent to Treat**
I, the Parent/Legal Guardian hereby consent to treatment for therapy services. I further understand that once a weekly treatment appointment schedule has been determined, this center is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advanced notice as possible for the center to attempt to accommodate this request. A change in time may necessitate a change in therapists as well.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that I will lose the cancelled session if not made-up within that same week. I understand that a make-up session may occur with this center's substitute therapist, regular therapist, or another skilled therapist with this center.

I understand that notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment(s).

I understand that the center is open except in cases of severe weather conditions requiring businesses to close. It is my responsibility to call the center to determine whether changes in the scheduled time of treatment are needed and if the opening of the center has been delayed. Families may cancel treatment if they do not wish to travel in poor weather conditions. I understand that if treatment time falls on a federal holiday that I am encouraged to make up these sessions.

I understand that if our therapist is ill or on vacation, the center may provide a substitute therapist to ensure continuation of services. This center will make every effort to schedule the therapist at our regularly scheduled appointment time. If this cannot occur, the center will provide an alternate appointment time.

I understand that if we do not keep a scheduled appointment or if we do not cancel a session before the session is scheduled to begin, that time of treatment is forfeited.

I have read and agree to abide by the above policies.

*Initials*_________

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Child's Name: ____________________________

**Office Policy for Families with Child Clients**
I understand that infants and toddlers often need to be accompanied by a parent during treatment; all other individuals are asked to please wait in the waiting room during treatment sessions. Observations of my child's treatment session may be scheduled upon request.

I understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and monitoring my child's play in the waiting room. I understand that the center prefers I wait during the session so that I am able to monitor some of my child's treatment when appropriate. I understand that it is the policy of this center that a parent or legal guardian must remain in the center during treatment sessions.

*Initials*________

**Acknowledgement of Risk**
I understand that there is some risk inherent in the use of therapeutic equipment at this center, and I agree to indemnify and hold the center harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment.

*Initials*________

**Coordination of Care**
I give permission to have this center contact and discuss my child's/my case with all persons whose names I have provided as professionals working with my child or myself.

*Initials*________

I give permission for this center to send copies of progress reports to all referral sources whose names I have provided.

*Initials*________

**Teaching and Education of Therapy Students**
I **give** permission for occupational, physical, and speech therapy students to observe my child's therapy.
I understand that I will be notified before such observation takes place.

*Initials**________
*optional

I **give** permission for photographs/videotapes to be taken of myself, or my child for educational and/or promotional purposes. I understand that any photographs or videotapes will be reviewed by me before they are released.

*Initials**________
*optional

**I have read, understood and agree to the terms of the treatment plan agreement at Helling Children's Center.**

| **Parent/Legal Guardian Signature** | **Date** | **Witness Signature** | **Date** |
|---|---|---|---|

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## Clinical Records Release/Request Form
## *Formulario de Publicación/Solicitud de Información Médica*

Date/*Fecha*: ___ / ___ / ___

Name/*Nombre*: ________________________________ Date of Birth/*Fecha de Nacimiento*: ___ / ___ / ___
Address/*Dirección*: ________________________________________________________________
City/State/Zip Code/*Ciudad/Estado/Código Postal*: ________________________________________
Telephone#/*Teléfono*: ___________________ Social Security #/*Número de Seguro Social*: ____ - ___ - ____

**I authorize Helling Children's Center to/ *Autorizo al centro para:***

☐ **Release – Releasing** information from Helling Children's Center to you or your provider
***Publicación*** *– Le suministramos la información siguiente a Usted o a su proveedor*

☐ **Request – Requesting** information from another provider to Helling Children's Center
***Solicitud –*** *Solicitamos la información siguiente de otro proveedor*

Information Requested or Released/*Información Solicitada o Publicada*:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

To/From/*Para/De*:

______________________________________________________________________
Address/*Dirección*: ________________________________________________________________
City/State/Zip Code/*Ciudad/Estado/Código Postal*:____________________________________________
Telephone#/*Teléfono*: __________________________________ Fax#: _____________________________

- I understand that this authorization shall be valid through (m/d/yr) ____ /_____ /_____ but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
*Entiendo que esta autorización será válida hasta ____ /_____ /_____ (fecha), pero puedo revocarla por escrito en cualquier momento; cualquier revocación no tendrá ningún efecto en las divulgaciones hechas previamente.*

- I understand that I have the right to inspect and copy the information released.
*Entiendo que tengo el derecho de examinar y de copiar la información suministrada.*

- I understand that if I refuse to consent the disclosure of information, the agency may be unable to serve me and/or be able to provide the most appropriate care for me.
*Entiendo que si decido no aceptar la divulgación de la información, la agencia podría no ayudarme y/o no podría proporcionarme el cuidado más apropiado.*

- I understand that the release of information may not be re-released to any other person or organization without my written consent.
*Entiendo que la publicación de la información no se puede volver a suministrar a cualquier otra persona u organización sin mi consentimiento por escrito.*

_______________________________________ _______________________________________
**Parent/Legal Guardian Signatura/** **Date/Fecha** Witness Signature **Date/Fecha**
***Firma del Padre/Madre/Tutor Legal*** ***Firma del Testigo***

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Child's Name: ____________________________

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## Advance Directives Policy

Helling Children's Center, LP requires each person receiving treatment in this facility to sign the following notice to be in compliance with the Self-Determination Act regarding advance directives. In this facility should a patient suffer a life-threatening situation this signed notice implies agreement on the resuscitation and transfer of the individual to a higher medical care. Therefore any previous signed advance directives, including durable power of attorney will not be observed in this facility. Concerns regarding this policy need to be addressed with your physician.

I have read the above policy and understand the information in this policy.

| ______________________________ | ______________________________ |
|---|---|
| **Parent/Legal Guardian Signature Date** | **Witness Signature Date** |

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Child's Name: ____________________________

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## Attendance Policy

Regular attendance is important for your child's progress in therapy. We at Helling Children's Center will make every effort possible to schedule your child's weekly appointments at a convenient time.

Therefore, our **Attendance Policy** requirements are as follows:

1. A 24 (twenty-four) hour cancellation notice (except in emergency situations).
2. For 2 (two) or more consecutive excused absences, a doctor's note is needed.
3. **All** No Shows are considered unexcused. After 2 (two) No Shows, the child will be removed from the schedule.
4. Regarding cancellations or tardiness, please keep in mind that excessive cancellations or tardiness will result in interruption of the child's plan of care.

**Too many unexcused absences, cancellations or tardiness can result in the loss of your child's scheduled time slot, at which time; he/she will be discharged and added to a waiting list for the next availability.**

I have read and understand the above policy.

______________________________________ ______________________________________

**Parent/Legal Guardian Signature Date** **Witness Signature Date**

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Child's Name: ______________________

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## Policy Regarding Sick Children

If your child is vomiting, has diarrhea, pink eye, a fever, or an active virus, please **DO NOT** bring your child to therapy. We are happy to reschedule your appointment. We will not count these absences against your child's attendance record. If you child is too sick to go to school, he/she is also too sick to come to therapy.

We reserve the right to deny services to sick patients.

I have read and understand the above policy.

| ______________________________ | | ______________________________ | |
|---|---|---|---|
| **Parent/Legal Guardian Signature** | **Date** | **Witness Signature** | **Date** |

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Child's Name: ____________________________

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## Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Helling Children's Center creates and maintains health records and other information describing among other things, my child's health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their Notice and practice prior to implementation, will mail copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services, and auditing functions, etc.) and the organization is not required to agree to restrictions requested.

By signing this form, I consent to use and disclosure of protected health information about my child for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided bylaw.

2. A photocopy or fax of this consent is as valid as this original.

3. I have had the right to request that the use of my child's Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must and agree to terminate any restrictions in writing on the use and disclosure of my child's Protected Health Information which have been previously agreed upon.

________________________________________
Patient's Name Printed

________________________________________ ________________________________________
**Parent/Legal Guardian Signature Date** **Witness Signature Date**

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Child's Name: ____________________________

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## Patient Responsibilities

**All patients/parents are responsible for the following:**

1. Behavior that shows respect and consideration for other patients, family, visitors and personnel of the Center.

2. Assuring that the financial obligations for health care rendered are paid in a timely manner.

3. Accepting consequences of their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given to them by the doctor or their health care team member.

4. Providing the Center to the best of their knowledge with an accurate and complete medical history about present complaints, past illnesses, hospitalizations, surgeries, and existence of advance directives, medications and other pertinent data.

5. Following the plan of treatment recommended by the doctor primarily responsible for the patient's care and/or other personnel authorized by the Center to so instruct patients.

6. Notifying the Center of any change in their condition or circumstances.

7. Keeping their appointment for scheduled services. If they anticipate a delay or must cancel the scheduled service, it is their responsibility to notify the Center as soon as possible.

8. The disposition of their valuables while at the Center is the responsibility of the patient or guardian.

______________________________________ ______________________________________

**Parent/Legal Guardian Signature** **Date** **Witness Signature** **Date**

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Child's Name: ___________________________
Medicaid #: _____________________________

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## HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your child's personal healthcare information. Please read it before signing.

**Helling Children's Center, L.P.** ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose and exchange specific health information from the records (written, electronic or verbal).

By signing this authorization you agree that the Covered Entity or its Business Associates may disclose your child's personal health information to:

| Name | Relationship to Child | Telephone Number |
|---|---|---|
| ____________________ | ____________________ | ____________________ |
| Name | Relationship to Child | Telephone Number |
| ____________________ | ____________________ | ____________________ |
| Name | Relationship to Child | Telephone Number |
| ____________________ | ____________________ | ____________________ |

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at its office or by sending a written request with return address to 12605 East Freeway, Suite 212, Houston, TX 77015.

You have the right to revoke this authorization in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained to be determined in the reasonable discretion of Covered Entity, or (d) one year from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for disclosure by the recipient and no longer protected by HIPAA.

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Child's Name: ___________________________
Medicaid #: _____________________________

Covered Entity will provide ________________________________ (Child's parent/legal guardian's name) with a copy of this signed authorization.

Acknowledge and agreed to by:

| ________________________________________ | ________________________________________ |
| --- | --- |
| **Parent/Legal Guardian (print name)** | **Relationship to Child** |
| ________________________________________ | ____________________ |
| **Parent/Legal Guardian Signature** | **Effective Date** |

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