Apple Patch Therapy & Learning

Phone: (407) 900-5313, Fax: (888) 972-5443
1858 Alafaya Trail, Ste. 207, Orlando, FL 32826
Email: Contact@ApplePatchTherapy.com
Website: www.ApplePatchTherapy.com

PATIENT INTAKE FORM (CHILD)

PERSONAL INFORMATION:

Child's Legal Name: _____ DOB: _____ SSN: _____

Address: _____ Phone: _____

Primary Insurance	ID #	Group #	Phone #
Secondary Insurance	**ID #**	**Group #**	**Phone #**

Available Days/Times: Mon: _____ Tues: _____ Wed: _____ Thu: _____ Fri: _____
Sat: _____ Sun: _____

Name	Phone	Email Address	Age	Occupation
Mother:				
Father:				
Other:				
Child resides with: ☐ Father ☐ Mother ☐ Grandparents ☐ Foster care ☐ Siblings ☐ Other →				

Primary Care Physician: _____ Phone: _____ Fax: _____

School / Daycare: _____ Director or Teacher: _____ Phone: _____

MEDICAL HISTORY

List any diagnosis		
Therapy History	☐ Yes ☐ No	Who, When, & Goals:
Specialists?	☐ Yes ☐ No	Details & When:
History of Ear Infections?	☐ Yes ☐ No	Details & When:
Hearing Difficulties?	☐ Yes ☐ No	Details & When:
Recurrent / Serious Illnesses	☐ Yes ☐ No	Details & When:
Surgeries, Serious Accidents	☐ Yes ☐ No	Details & When:
Allergies	☐ Yes ☐ No	Details & When:
Medications	☐ Yes ☐ No	Details & When:
Vision Problems	☐ Yes ☐ No	Details & When
Dental Problems	☐ Yes ☐ No	Details & When
Other Medical Problems	☐ Yes ☐ No	Details & When:

DEVELOPMENTAL HISTORY

Provide approximate age when patient met the following developmental milestones:

Crawl _____ Sit _____ Stand _____Walk _____ Feed Self _____ Dress Self _____
Use toilet _____ Babble _____ Use single words _____ Combine words _____
Name simple objects _____ Use simple questions _____ Engage in conversation _____

Describe patient's response to sound (response to loud, all, or specific sounds)	Details:

Does patient have any feeding-related problems (*sucking, swallowing, drooling, etc.*)?	☐ Yes ☐ No	Details:
Does patient have difficulty walking, running, or participating in other activities?	☐ Yes ☐ No	Details:

EDUCATION HISTORY

Current Grade:	Has your child ever been retained? ☐ Yes ☐ No	When?
Academic Performance	☐ Below ☐ Average ☐ Above Details:	
Are there behavior issues?	☐ Yes ☐ No - If yes, explain:	
Is the patient enrolled for special education services or has an Individual Education Plan? ☐ Yes ☐ No Details & description of priority goals:		

COMMUNICATION / SOCIAL HISTORY AND BACKGROUND

Language(s) spoken at home	Primary: Other:
What motivates your child?	
What are his/her interests (sports, shows, movies, toys, activities)?	

Describe concerns & patient's communication problem:	Details:	
How does he/she communicate with others (single words, short phrases, gestures, etc.)?		
How does the child interact with others (uncooperative, shy, aggressive, etc.)?		
What do you think may have caused the problem?		
Has the problem changed since first noticed?		
Describe his/her response to sound (loud, all, or specific sounds)		
When was the problem first noticed? By whom?		
Is patient aware of problem?	☐ Yes ☐ No	If yes, how does the patient feel about it?
Family history of related problems?	☐ Yes ☐ No	If yes, please describe and give relation (uncle, grandfather, etc.)
Please provide any additional information that will help in the evaluation & remediation process.		

I hereby attest that the information provided is true to the best of my knowledge, and I authorize any prior or present treating physician, therapist, school, hospital or other health institution, to release all of medical information by any means of communication to Apple Patch Therapy.

Name of Parent / Caregiver (print) **Signature** **Date**

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

JAND GROUP, LLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

A government rule, called the Health Insurance Portability and Accountability Act, or HIPAA for short, requires that you get a copy of this privacy notice. We will ask you to sign a paper saying that you have been given this notice. Read and refer to this notice at any time to see how your health information can be used & who can see it.

How Your Health Information May be Used or Shared

We may use or share your health information without your permission for the following reasons:

- **Treatment**. We may share information with doctors & other health care providers who care for you. For example, if your doctor orders speech therapy, we will share results of our treatment with that doctor.
- **Payment.** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information. We may share information to:
- Get the insurance company's permission to start treatment
- Get permission for more treatment
- Get paid for the treatment you receive
- **Health Care Operations.** We may use and share your health information to run our practice and be sure that all patients receive good care. For example, we may use your health information to:
    - See how well our services are working
    - See how well our staff is doing
    - See how we compare to other therapy companies
    - Make our services better
    - Help others study health care services

Your Health Information May Also Be Used or Shared Without Your Permission for:

- **Abuse and Neglect.** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders.** We may use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by e-mail, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law.** We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Government Functions.** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Public Health Risks.** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight.** We may use or share your information with agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
- **Threats to Health and Safety.** Your health information may be shared if we believe that it will prevent a threat to your health and safety or the health and safety of others.
- **Worker's Compensation.** We will share your information with Worker's Compensation if your case is being considered as a work-related injury or illness.

When Your Permission is Needed to Use or Share Your Health Information

You must give us permission to use or share your health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get back the information that we shared with your permission.

Your Privacy Rights: You have the right to:

- **Ask us not to share your information.** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to contact you only in a certain way or at a certain place. For example, you may want us to call you but not to e-mail you. Or you may want us to call you at work and not at home. You must ask us in writing. We will do all we can to do what you ask.
- **Look at and copy your health information**. You have the right to see your health information and to get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information**. You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared.** You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
    - You need to ask us in writing.
    - You must tell us the dates you are asking about and if you want a paper or electronic copy.
    - You may get information going back 6 years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.
- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.
- **File complaints.** You can file a complaint with us or with the government if you think that
    - o Your information was used or shared in a way that is not allowed
    - o You were not allowed to look at or copy your information
    - o Any of your rights were denied

Who is Covered by This Notice

The people who must follow the rules in this notice are:

- All speech-language pathologists and staff working at JAND Group LLC

Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and to any new information. Copies of the new notice will be available from our staff.

Complaints: You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints, go to www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. All complaints must be in writing.

By signing this form, I acknowledge that I have received a copy of Apple Patch Therapy's HIPAA practices and have read and understand their policies.

_____	_____
Patient Name (Print)	Patient Date of Birth

_____	_____	_____
Signature of Patient or Guardian	Printed Name	Date