Rainbow Rehab LLC

Pediatric Occupational · Physical & Speech Therapy Services

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Facility: 141 Futral Rd, Griffin, GA 30224 and 2251 HWY 42 N, McDonough, GA 30253
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PATIENT BILLING INFORMATION

Patient Name: _____ Parent's Name: _____

Patient DOB: _____ Patient Sex: ☐ M ☐ F Diagnosis: _____

Parent/Caregiver Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Physician's Name/Number: _____ Physician's Fax Number: _____

INSURANCE INFORMATION

Insured's Name: _____ Relationship to Patient: _____

Employer: _____ Insurance Carrier: _____

Address: _____

Phone Number: _____ Policy Number: _____ Group Number: _____

Deductible: _____ Benefits: _____ Do you have a copy of the card? Y N

MEDICAID/CMO COVERAGE

Medicaid: Number _____ ☐ Straight Medicaid ☐ Medicaid SSI ☐ Deeming Waiver

CMO: ☐ Amerigroup ☐ Peach State ☐ Caresource

EMERGENCY CONTACT

Name: _____ Relationship: _____ Cell Number: _____

ADDITIONAL PATIENT INFORMATION

Diagnosis: _____

Reason for Referral [Please include recent evaluations and/or notes]: _____

_____

Current Medications: _____

Are you receiving any other therapies at this time? If so, please describe: _____

_____

Parent Goals for ABA/Therapy: _____

_____

Policy Statement & Financial Agreement

Insurance: It is the parent / guardian's responsibility to notify Rainbow Rehab of any changes in insurance information. We require payment at time of service however as a service to our clients we will file your claims with your insurance company. We will verify your insurance benefits however this does not guarantee payment for therapy services. Parents / Guardians are ultimately responsible for their child's therapy bill.

Assignment of Benefits / Authorization to Release Medical Information / Consent to Treatment:
I hereby assign all medical benefits to which I am entitled to: Rainbow Rehab, LLC in the event that they file insurance on my behalf. I understand that I am financially responsible for all charges whether they are paid or not by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. Including but not limited to collection service fees, attorney's fees, and all court cost and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 20% per month for unpaid balances over (90 days old) thereby authorize said assignee to release all information necessary to secure the payments of said benefits a copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized therapy staff of Rainbow Rehab, LLC as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability of such treatment excepting acts of negligence. By signing this form, I authorize Rainbow Rehab, LLC and its billing agent, Medbill Solutions, Inc. to release my child's requested medical records to my insurance company, Medicaid, and other HIPPA compliant companies to obtain payment or services for to my child.

Parent / Guardian Signature: _____ Date: _____

Outpatient Therapy Scheduling and Attendance Policy

Scheduling:
ABA Therapy sessions and scheduling will be determined by the therapists/BCBA and parents will be notified. Prompt drop- off and pick up is appreciated as our appointments are scheduled back to back. While observing sessions is encouraged, parents must be available by cell phone if leaving the building. We also request that parents or caregivers return at least 10 minutes prior to the end of any session to help us stay on schedule for our next appointment.

Attendance Policy:
Children will be scheduled for outpatient therapy appointments once all required documents and insurance approvals have been received. (Children will be scheduled at a mutually agreed upon day and time every week. Once established, this day / time will be changed only if necessary.) Reminder phone calls or texts will be sent the day prior to the appointment. Every effort will be made to re-schedule appointments missed due to therapist absences.

Missed / Cancelled Appointments:
A minimum of 24 hour notice is requested to cancel therapy appointments. All missed appointments will be documented in the child's medical record. A "no show / no call" missed appointment adversely affects both the child and Rehab staff and may result in a discontinuation of therapy services from Rainbow Rehab, LLC. Excessive absences from scheduled therapy appointments may also be grounds for discontinuation of therapy services. Excessive absence is defined as 50% or more missed appointments in a three month time period.

Parent / Caregiver Signature:
I have read the Rainbow Rehab, LLC Outpatient Therapy Scheduling and Attendance Policy and agree to abide by the terms as outlined.

Parent / Guardian Signature: _____ Date: _____

Photo/Video Consent Form

Consent is hereby given to Rainbow Rehab LLC. with approval of (parent/guardian)_____ to take videotape and photographs of (student name) _____.

These photographs and videos will be used for the purpose of staff or parent training, publications, marketing, research, and participating in typically-occurring therapy activities. Rainbow Rehab LLC. will also accept any video or photographs which parents choose to provide to Rainbow Rehab LLC.

I understand that I have the right to view all videos and photographs collected by Rainbow Rehab LLC. staff. If I wish to do so, I will notify the owner in writing.

I further consent to give Rainbow Rehab LLC. the right and permission to use my name, my child's name, and/or my written or spoken words for reproduction in any publication or media prepared by Rainbow Rehab LLC.

Parent / Guardian Signature: _____ Date: _____

Developmental History

CHILD'S INFORMATION

Child's Name: _____

Age: _____ DOB: _____ Gender: ☐ M ☐ F

Address: _____

Current School: _____

Areas of Disability: _____

_____

Name/Age/Sex/Relation of Additional Children in the Household: _____

_____

_____

Language Spoken in Household:_____

PARENT(S) INFORMATION

Father's Name: _____ Occupation: _____

Phone: _____ Work Phone: _____ Email: _____

Address (if different from above): _____

_____

Mother's Name: _____ Occupation: _____

Phone: _____ Work Phone: _____ Email: _____

Address (if different from above): _____

_____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single

EMERGENCY CONTACT(S) AND RELEASE PERSON(S)

Name: _____ Phone Number: _____

Address: _____

Name: _____ Phone Number: _____

Address: _____

MEDICAL AND THERAPEUTIC INFORMATION

Child's Pediatrician: _____ Number:_____

Address: _____

Please list Any Allergies or Reactions Your Child Has: _____

_____

Complications, illnesses, infections or stress during pregnancy? Y/N (describe) _____

Complications during labor and delivery? Y/N (describe) _____

Forceps/Vacuum/C-Section? Y/N (describe) _____

Weeks gestation? _____

Birth Order _____ Birth Weight _____ Apgar Score at 1 Minute: _____ 5 Minutes _____

Premature/Post Mature/Full Term *(please circle one)* **Strong suck?** Y/N **Spit up frequently?** Y/N

Complications with feeding? Respiration? Sleeping? Please circle one and describe: _____

_____

ACADEMIC INFORMATION

Please describe the type of classroom setting where your child is/was: _____

_____

Does your child enjoy art or music? If so, please list the activities: _____

_____

How would you describe your child? Circle all that apply.

- ☐ • Usually very active
- ☐ • Usually not active, has to be prompted
- ☐ • Can be moody
- ☐ • Aggressive towards self and/or others
- ☐ • Lacks confidence in self
- ☐ • Prefers motor activities
- ☐ • Separation anxiety
- ☐ • Active sometimes but can play quietly
- ☐ • Usually happy
- ☐ • Demands excessive attention
- ☐ • Short attention span
- ☐ • Enjoys playing with others
- ☐ • Prefers sit-down activities

Does your child have outbursts or meltdowns due to anger, frustration and/or overload? Y/N

If yes, please explain and how often: _____

_____

Does your child have strong fears/anxiety? Y/N Describe: _____

What kind of play or recreational activities does your child seem to enjoy the most? _____

_____

What are his/her favorite items? _____

Does your child enjoy playing… *(please circle)*

Alone (Y/N) With younger children (Y/N) With similar aged children (Y/N) With adults (Y/N) Groups (Y/N)

DEVELOPMENTAL MILESTONES

Please note approximate age at which he/she did the following:

Sat _____	Belly Crawled _____	Crawled _____ Cruised_____
Walked _____	First Words _____	Talked _____
Undressed Self _____	Dressed Self _____	Toilet Trained _____
Tied Shoes _____	Began Pre-School _____	Snaps/Buttons/Zippers _____

Ear infections? Y/N Please describe_____

Seizures? Y/N Please describe_____

Injuries? Y/N Please describe_____

Hospitalizations? Y/N Please describe_____

Glasses? Y/N Please describe _____

Medications? Y/N Please describe _____

Preferred hand? Please circle one: Left ☐ Right ☐ No Preference ☐ Age established? _____

Has your child ever been seen by a developmental or clinical psychologist? Y/N

If so, what was the name of the professional? _____ Date of last visit? _____

Has your child ever been seen by a developmental pediatrician? Y/N

If so, what was the name of the professional? _____ Date of last visit? _____

Has your child ever been seen by a clinical psychiatrist? Y/N

If so, what was the name of the professional? _____ Date of last visit? _____

Please indicate all therapeutic or educational interventions that your child is receiving now. Please include the name of the provider and the frequency: _____

_____

**Please include a copy of IEP, IFSP, most recent therapy evaluations if transferring from another practice.*

Telehealth Member Consent Form

Patient Name: _____

Date of Birth: _____ GA Med ID#:_____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s): _____

2. NATURE OF TELEHEALTH CONSULT: During the telehealth consultation:

a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.

b. A physical examination of you may take place.

c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.

d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. RIGHTS: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. DISPUTES: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____ Date: _____

Printed Name: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____

ABA Intake & Indirect Assessment Survey

*Please be as specific as possible.

CHILD'S INFORMATION

List and describe behavior(s) of concern: _____

_____

_____

What procedures have been followed when the behavior(s) first occurred? _____

_____

_____

What do you think causes the behavior(s)? _____

_____

_____

When does the behavior(s) occur? _____

_____

How often has this behavior(s) been occurring? _____

_____

What are the circumstances under which the behavior(s) does not occur? _____

_____

_____

Under what circumstances do the behavior(s) always occur? _____

_____

_____

Does the behavior(s) occur more often during certain times of the day? If so, when? _____

_____

_____

Does the behavior(s) occur in response to the number of people in the immediate environment? _____

_____

_____

Does the behavior(s) occur with certain people? If so, who? (Provide relationship to individual): _____

_____

_____

Does the behavior(s) occur only during certain classes/activities? If so, which? _____

_____

_____

Will the child run away from you if not closely monitored? _____

_____

Is the child taking medication that might affect his/her behavior(s)? _____

_____

Is the child's behavior(s) signaling some type of deficit *(thirst, hunger, lack of stimulation)*? _____

_____

Does the child have any sensitivity to sound/light/touch/smell, or get upset at loud noises, wearing certain clothes, smells everything, doesn't like hands/mouth dirty? _____

_____

Are they a picky eater? If so, what types of food do they prefer? _____

_____

_____

Does the child climb on things often? _____

_____

Does the child have difficulty stopping one activity to start another? _____

_____

Does the child engage in self-injurious behavior(s)? ie: hitting, scratching, hurting themselves _____

_____

Does the child put nonedible items in their mouth? If so, do they attempt to ingest it or chew on it? _____

_____

_____

Child's Current Behaviors and Expected Outcomes: _____

_____

_____

Please provide detail regarding the concerns of your child's development, if any: _____

_____

_____

Please describe any problem behaviors or interfering behaviors of concern: _____

_____

_____

Please state the expectations/goals that you have for your child while engaging in a behavioral program: _____

_____

_____

_____

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

_____

_____

_____

Please state the preferred number of therapy hours, and dates/times that would be most convenient for your child and your family: _____

_____

_____

*I HAVE READ THE PARENT INFORMATION SHEET AND AGREE TO THE TERMS.

Parent / Guardian Signature: _____ Date: _____