Path To Progress, LLC
Speech • Occupational • Physical
www.pathtoprogresstherapy.com
803.802.5508

CASE HISTORY

PERSONAL INFORMATION

Child Name:	Gender: Male Female	DOB:	Age:
Address: (Street, City, State, Zip Code)		Diagnosis/Problem:	
Parent/Caregiver Name(s):		Relationship to Patient:	

Primary Phone #:	Secondary Phone #:	Work Phone #:	E-Mail Address:
Emergency Contact: (Different From Above)		Phone #:	Relationship to Patient:

PREGNANCY & DELIVERY HISTORY

Pregnancy	□ Full Term	□ Pre-term: # wks_____	□ Post-term: # wks_____
□ Vaginal	□ Caesarean	□ Breech	□ Twins or more: #
Weight at Birth: _____	Length at Birth:_____	Length of stay in NICU(if applicable):_____	
Conception Method	□ Natural □ IVF □ In-Vitro □ Surrogate		

QUESTION	**ANSWER**		**DETAILS**
Was prenatal care received? *(If YES, what month was it initiated)*	**NO**	**YES**	
Any medical concerns prior to and/or during pregnancy? *(If YES, please explain in detail)*	**NO**	**YES**	□Preeclampsia □Eclampsia □Gestational diabetes □High blood pressure
Any emotional concerns prior to and/or during pregnancy? *(If YES, please explain in detail)*	**NO**	**YES**	
Is your child adopted? *(If YES, please answer the following in detail)* A.) When and where did adoption occur? B.) Do you know any birth history, foster care, orphanage details, etc.? C.) Does child know he/she is adopted	**NO**	**YES**	A.) B.) C.)

Please describe any complication at birth or afterwards: (ie. Induced, emergency caesarean, forceps, suctioned, etc)

DEVELOPMENTAL HISTORY

Please indicate at what age your child began:

SKILL	AGE	DETAILS
• Roll over		
• Crawl		
• Pull to stand		
• Reach for toy		
• Walk		
• Isolate fingers to count		
• Breast feed		
• Bottle feed		
• Eat finger foods		
• Babble		
• Say first words		
• Pair two words		
• Recognize familiar faces		
• Recognize familiar voices		
• Blow nose		

SURGICAL HISTORY

Please list all surgeries and hospitalizations your child has had.

Surgeries/Hospitalizations:	Date:	MD/Surgeon:	Condition/Details:

MEDICAL HISTORY

Please check "√" all that apply.

□ Anoxia	□ CMV	□ Juvenile Arthritis	□ Traumatic Brain Injury
□ Allergies:_____	□ Down Syndrome	□ Plagiocephaly	□ Visual Problems
□ Asthma/	□ Ear Infections	□ Pneumonia	□ Torticollis
□ Autism/PDD	□ Headaches	□ Prematurity	□ Jaundice
□ Balance Problems	□ Heart Problems	□ Seizure/Epilepsy	□ Cyanosis
□ Cancer	□ Hepatitis	□ Speech/Lang Problems	□ Other:
□ Cerebral Palsy	□ HIV/AIDS	□ Swallowing Problems	□ Other:

MEDICATION HISTORY

Please list current medications, dosage and the condition the medication is treating.

Medication	Dosage	Condition

INTERVENTION HISTORY

Please list the names of any specialists that have evaluated your child, date of the evaluation & any diagnoses.

Specialist Name	**Date of Evaluation**	**Diagnoses**

HEARING/AUDIOLOGY HISTORY

Has your child every received a hearing screen or a formal evaluation to test their hearing? **YES** **NO**

When & Where:	**Results:**	**History of ear infections (# if yes)?**

FAMILY/SOCIAL HISTORY

Please list the names, ages and relation of those living in your home.

Name	**Age**	**Relationship to child**

My child's primary care giver is:

What kind, if any, outside play area does your child have access to:

Does your child have his/her own bedroom or share?

My child's sleeping habits: (location & hours)

Describe the discipline methods used at home:

Describe any significant changes your child has experienced in the past 3 months:

Are there any religious, spiritual, or ethnic customs your therapist should be aware of? Please describe:

My child's strengths are:

Please describe your child's play skills:

What do you hope you and your child will gain from participating in therapy?

SELF CARE SKILLS

Please circle the "%" level that indicates the level of independence your child demonstrates with the following skills.

• Brushing teeth	0%	25%	50%	75%	100%
• Bathing	0%	25%	50%	75%	100%
• Dressing	0%	25%	50%	75%	100%
• Toileting	0%	25%	50%	75%	100%
• Self feeds	0%	25%	50%	75%	100%
• Use of utensils	0%	25%	50%	75%	100%
• Sippy cup	0%	25%	50%	75%	100%
• Open cup	0%	25%	50%	75%	100%
• Straw drinking	0%	25%	50%	75%	100%
• Sits for meals	0%	25%	50%	75%	100%
• Organizes homework	0%	25%	50%	75%	100%
• Answers basic questions about self (name & age)	0%	25%	50%	75%	100%
• Recognizes printed name	0%	25%	50%	75%	100%
• Asks for help	0%	25%	50%	75%	100%

SCHOOL/DAY CARE HISTORY

Child's current School/Day Care and grade/placement:

Do I have permission to contact your child's school teacher/therapists? If **YES** please sign separate consent to release information.

My child receives the following support services at school:

My concerns surrounding my child and her/his school:

What other information can you tell me about your child?
What questions do you have regarding therapy and your child?

- Path to Progress will concentrate efforts on improving speech and language skills, enhancing behavior and play skills as well as establishing habits that produce success at home and at school. Sessions may also include coaching parents in ways to modify child behavior, increasing compliance and developing self-esteem.

- Information regarding your child, including current and past medical history is necessary to develop an accurate profile of the child prior to treatment. At no time will this information be shared outside of this office or for any reason outside of the scope of your child's treatment at Path To Progress without your expressed written consent.

- Path to Progress recognizes that the clients will likely discuss confidential issues during the sessions, any of which might include: family issues or concerns, marital difficulties, problems with children, future plans, financial information, job information, goals, personal information, and other private information. Path to Progress will not at any time, either directly or indirectly, voluntarily disclose, or communicate this information to a third party. Path to Progress will not voluntarily divulge that Path to Progress and the client are in a therapeutic relationship without the expressed written permission of the client. This confidentiality agreement does not apply to illegal activities, child abuse, or plans to conduct harmful or illegal activities.

- Your signature upon this document indicates your acceptance of all conditions and policies listed therein and you consent to having your child treated by Path to Progress for speech, physical, and/or occupation therapy services.

Signature of person completing this form: _____ Date:_____

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FINANCIAL POLICY

Thank you for choosing us as your specialty care provider.

PRIVATE PAY

If you choose to pay privately, then you hereby waive the use of any insurance coverage and agree to pay in full all amounts due at the time of service. Int:_____

INSURANCE

PATH TO PROGRESS, LLC will discuss your insurance coverage and financial responsibility prior to the commencement of any therapy or evaluations. Non-Medicaid clients will be presented a break-down of benefits directly from their insurance. We do require copayments, deductibles, and non-covered charges to be paid at the time of services. Please be aware that some, and perhaps all, of the services provided may not be covered under your particular benefit plan. Any verbal verification of benefits or coverage is never a guarantee of payment. **If your insurance company has not paid for services in full within 30 days, the balance will automatically be billed to your account and in invoice will be sent to you.** Invoices must be paid within two weeks of invoice date to prevent suspension of therapy services.

Int: _____

MEDICAID

PATH TO PROGRESS will accept Medicaid for therapy services including speech/occupational/physical with a current Medicaid card and authorization from DMA/DHHS. Private insurance must be billed prior to accessing Medicaid funds. Services not billable to Medicaid must be paid in full at the time of service. Int: _____

CHANGES IN INSURANCE / MEDICAID POLICY

Parents/guardians are responsible for notifying PATH TO PROGRESS of any changes in insurance / Medicaid coverage. Any payment denials or delays resulting in changes in coverage will result in IMMEDIATE transfer of full amounts due to the client. Int: _____

UNPAID MEDICAID BALANCES

If an outstanding balance exists after two weeks, we will notify you of the amounts owed and ask that you contact your Medicaid case manager to discuss the account. If the balance is not paid within 30 days, services will be put on hold until payment is received. . Int: _____

MINOR CLIENTS

Parents/guardians are responsible for payment. In the case of divorced parents, foster care parents, etc., the adult who arranges for services for the minor is responsible for payment. Int:_____

CANCELLATION and NO-SHOW POLICY

Patients that cancel with more than 24 hour notice will not be subject to a cancellation fee. Each client is required to maintain 80% attendance during any continuous 12 week timeframe, regardless of cancellations being excused or not. Patients failing to maintain the 80% attendance rate will be removed from their scheduled timeslots. Any patient that no shows for an appointment or cancels less than 24 hours without a prior call or email will immediately be subject to a $25 cancellation fee. We understand emergencies and illnesses do happen, and we are glad to work with you should one of those situations arise. If a patient schedules and attends a make-up session within one week (before or after) the cancellation, the cancellation fee will be waived and will not count as a missed appointment. An Invoice will be sent via email to collect any issued fees. Any fees assessed will be due immediately and before your child can be seen again.
Int: _____

TERMINATION

You may terminate speech or occupational therapy at any time. Cancellations must be in writing, at least one week notice to avoid cancellation/no-show fees. Int: _____

EMAIL / PHONE POLICY

Path to Progress will provide email consultations under the following conditions: in cases where there is need for clarification of tasks/guidelines, when the therapist can address the concern with a single replay, requiring less than a 10 minute response. Any response requiring more than 10 minutes of the therapist's time will be considered a private consultation, and fees will apply based on the current fee scale. Int:_____

I acknowledge primary responsibility for the payment of service to PATH TO PROGRES. I have read, understand and agree to the above.

_____
Print Guarantor Name

_____
Guarantor Signature Date

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CONSENT TO VIDEO-TAPE and/or PHOTOGRAPH THERAPY SESSIONS

Dear Parent,

For training and supervisory purposes, it is often very helpful to video-tape therapy sessions with our children.

However, privacy and discretion is of supreme importance in this industry (and to us), so we require therapists to obtain expressed written consent from parents, before any sessions can be video-taped or photographed.

Videos are viewed only by your child's therapists and the therapists' immediate supervisors. Videos are used to provide guidance and instruction from the supervisors to the therapists.

We would also like to use some photographs for display in the office, office advertising, and social media outreach (ie: Facebook and our own website).

If you agree to allow Path to Progress to video-tape and/or photograph therapy sessions with your child, please sign and date the following acknowledgement and consent statement:

✂ ---

Complete and return to your child's therapist.

☐ I give permission for my child's therapy sessions to be video-taped and/or photograph for training, supervisory, advertising, and social media outreaches purposes. I understand that my consent is voluntary and may be revoked by me at any time.

Child's Name: ______________________________ Date of Birth: ______________

Therapist: ____

Parent/Guardian Name (printed): ______________________________

Parent/Guardian Signature: ________________________________ Date: ________