Thrive
Pediatric Therapy & Family Services
phone: (843) 839-9494 | fax: (843) 839-9544
1304 Azalea Court, Suite A Myrtle Beach, SC 29577
ThrivePediatricTherapySC@gmail.com
www.ThrivePediatricTherapySC.com

Consent Form/HIPAA Acknowledgement Form

I have been informed of the use and release of information collected through services received in regard to: _____(print patient's full name). I request that copies of information in regard to my child be released to/from:

1 _____ (Child's Doctor)
2 _____ (School/Daycare- if appropriate)
3 _____ (Other Doctors)
4 _____ (BabyNet -if appropriate)
5 _____ (Payer/Insurance)
6 _____ (ABA Company -if appropriate)
7 _____ (Other)
8 _____ (Other)

Please read and initial each of the following:

_____ I request that payment of authorized Medicaid and third-party payer's benefits be made to Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC on my behalf for services furnished to me.
_____ I authorize Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC to release any medical information about me that may be needed to determine these benefits payable for related services.
_____ I understand that I will not be billed for any Medicaid services furnished to me which were billed to Medicaid during the time I had Medicaid coverage for those services.
_____ I understand that Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC are required by law to keep my health information safe. This information may include notes from your doctor/teacher/other health care providers, medical history, test results, treatment notes, and insurance information.
_____ Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC have given me a copy of their privacy notice. I understand that they are required by law to give me a copy of their privacy notice and this notice tells me how my health information may be used and shared. It also tells me how I can look at and comment on my information.
_____ I consent to have my child treated by Thrive Pediatric Therapy & Family Services LLC for Speech Language Therapy Services and/or Occupational Therapy Services.
_____ I understand that Thrive Pediatric Therapy & Family Services LLC is a teaching facility and student clinicians will be observing and treating patients.

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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Attendance and Cancellation Policy

Attendance:
Thrive Pediatric Therapy and Family Services requires consistent attendance. Consistency helps ensure quality services are provided and progress is made towards each individual's goals. The most common reason for lack of progress is poor and inconsistent attendance. The items below will help ensure that we are able to meet the needs of your child:

1. Thrive Pediatric Therapy and Family Services will send (with permission) an email reminder the day before your scheduled appointment. **Attendance is not dependent upon the receipt of an email reminder.**
2. Please arrive at the clinic 10 minutes prior to the start of your child's session.
3. Client's who arrive more than 15 minutes late for a session are seen at the discretion of the therapist. Appointment times will not be extended to accommodate for the missed time.

Cancellations and No shows:
Repeated violation of the cancellation and attendance policies may result in your child losing their spot on a caseload or permanent discharge from therapy. Our goal is to be as accommodating as possible; if your scheduled appointment time does not work well for your family's schedule, please speak with your treating therapist about making arrangements to attend at a different time, schedule permitting. Listed below are our cancellation and attendance policies:

1. If you need to cancel an appointment, for a pre-planned event such as a family vacation, sporting event, doctors appointment, etc, we ask that you **provide at least 24 hours notice**. If the office is closed, please leave a message on the answering machine with the date and time that you called. Our office number is (843) 839-9494.
2. We anticipate unforeseen circumstances arising and emergencies happening; in this case, we ask that you call as soon as you realize that your child will be unable to attend their therapy session. Emergency cancellations are constituted as an illness of the client, illness of a family member or death in the family. Again, you can leave a voicemail on the answering machine 24 hours a day to notify us of the cancellation.
3. A "no-show" visit will be documented and reported to the referring physician and insurance company quarterly. Excessive no show visits may result in the insurance company denying authorization for continued therapy services. After three no show visits, it is also up to the discretion of the therapist to discharge the client from therapy.
4. We do our best to reschedule all canceled sessions. It is our goal to reschedule 50% of missed and canceled visits.

Weather Closures:

Thrive Pediatric Therapy and Family Services follows all weather related closures of Horry County Schools.

- If Horry County Schools are closed due to weather, Thrive Pediatric Therapy and Family Services will be closed as well.
- Thrive Pediatric Therapy and Family Services will NOT delay openings, even if Horry County Schools enacts morning delays, likewise we will continue normal operating hours in the event of early dismissal from school.
- Regardless of school closures, parents are responsible for using their best judgment when inclement weather arises. If you feel as though it is unsafe to drive, please call and cancel your appointment. Appointments canceled due to inclement weather will not be subject to penalization.

Holiday Closures:

Thrive Pediatric Therapy and Family Services will be closed in observance of the following holidays:

- New Years Day
- Presidents Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day **AND** the day after
- Christmas Eve **AND** Christmas Day

**The clinic will close at the end of business hours on December 23rd and remain closed until the start of business on January 2nd. This allows both our therapists and clients sufficient time to relax and enjoy the holiday season with their family and friends in anticipation of starting the new year refreshed.

Please sign below in acknowledgement of the set forth Attendance and Cancelation Policy. A summary of this policy can be found in the parent handbook to be reviewed when needed.

I, _____, have read the above attendance policy and understand that my cooperative and participation contributes to the success of my child's therapy program. In addition, I agree to abide by these policies while my child is receiving services at Thrive Pediatric Therapy and Family Services; failure to do so may result in discontinuation of therapy services.

Parent Signature: _____ Date: _____

Witness: _____ Date: _____

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Illness Policy

Parents/Guardians must call or text Thrive Pediatric Therapy and Family Services to cancel/reschedule appointments if your child has one or more symptoms of a contagious disease. We appreciate your partnership in keeping one another as healthy and safe as possible.

<table>
<tr><th colspan="3">WHEN TO STAY HOME</th></tr>
<tr><td>FEVER
Any fever over 100.4 should be kept home until 24 hours fever free without any medicine.</td><td>VOMITING & DIARRHEA
Any vomiting or diarrhea in the last 24 hours should be kept home.</td><td>HEAD LICE/ NITS
Children should stay home until lice/nits are no longer present.</td></tr>
<tr><td>COUGH & COLD
Disruptive and/or productive coughs, nasal drainage, discolored phlegm, sneezing should be kept home.</td><td>EYE INFECTION
Redness, itching and/or “crusty” drainage from the eye. Must be evaluated and released by a doctor to return.</td><td>RASH
Rash with itching or fever. May return when the rash is gone or when evaluated and released by a doctor.</td></tr>
<tr><td colspan="3">GENERAL ILLNESS
If your child has any contagious illness like strep throat, impetigo, hand foot & mouth disease, chickenpox, etc. please keep them home. You know your child best. If they are under the weather and you think they would benefit from staying home, getting rest, and not spreading germs then that is what you should do.</td></tr>
</table>

I agree to abide by the above stated policy.

Child’s Name: _____

Parent / Guardian Signature: _____ Date: _____

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Photo/Audio/Video Release Form

Thrive Pediatric Therapy & Family Services LLC is requesting your permission to take photographs and/or video recordings of your child.

PLEASE COMPLETE ONLY ONE SECTION

I hereby voluntarily and without compensation authorize Thrive Pediatric Therapy & Family Services LLC, its representatives and employees the right to take photographs and/or video recordings of my child for the following uses: (Check all that apply)

- ▢ To assist in evaluation/treatment/assessment
- ▢ To communicate progress to me via text or email
- ▢ To communicate progress (via text or email) to specialists working with my child (ex. teachers, therapists, doctors) for which I have signed an authorization for release
- ▢ For display inside the clinic
- ▢ For educational/training materials for professionals and other parents
- ▢ On printed materials and brochures
- ▢ On the company website
- ▢ On company social media channels

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Child's Name _____ Date _____

▢ I choose NOT to give permission for Thrive Pediatric Therapy & Family Services to take photographs and/or video recordings of my child.

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Child's Name _____ Date _____

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Intake Form

Today's Date: _____

Identifying and Family Information:

Child's Name:_____ Child's Date of Birth: _____
Child's SS#: _____ _Child's Sex: _____
Name of Daycare/School: _____ Grade:_____
Does your child receive therapy services at school? Please list. _____
Does your child have an IEP? ___Yes___No
Does your child attend ABA Therapy ___Yes___No ABA company name _____
Who does the child live with? Please include all adults (name only), children (names, ages), and pets (name, animal type): _____

Parent/Guardian names: _____
Address: _____
Daytime Phone: _____Cell Phone: _____
Email: _____
Are there any child custody issues? ___Yes___No If yes, please bring supporting court documents.

General Information:

What are your child's strengths?

_____
_____

What are your concerns about your child?

_____
_____

What are your primary goals for your child?

_____
_____

Pregnancy and Birth History:

Describe any complications during pregnancy, labor, or delivery: _____
_____

Method of delivery: ___ Vaginal ___Scheduled C Section ___Emergency C Section
Was your child premature? ___Yes ___No How many weeks gestation?_____ Weight:_____
Did your child require any medical intervention or assistance? Please describe. _____
_____

Medical History:

Is your child currently taking any medications? ___Yes___No Please list below.
_____
Please describe any diagnoses, major illnesses, hospitalizations, surgeries, or imaging that your child has had done. _____
_____
_____
_____
_____
Please list any allergies your child has (include food sensitivities/intolerances):_____
_____
Has your child's hearing ever been tested: ___Yes ___No Date of testing: _____
Results of testing:_____

Developmental History:

Skill	*Age Appropriate*	*Delayed*	*Notes*
Rolling (4-6 months)			
Sitting alone (4-7 months)			
Crawling on all 4's (6-10 months)			
Pull to stand (9-12 months)			
Standing alone (11-14 months)			
Walking (11-15 months)			
Babbling (6-11 months)			
Saying single words (12-17 months)			
Combining words (18-23 months)			

Social/Play/Academic Development:

Skill	*Yes*	*No*	*Notes*
Finger feeds			
Eats with spoon/fork/knife			
Cuts with scissors			
Colors			
Rides a bike			
Jumps/Hops			
Skips			
Performs handwriting tasks			
Sleeps well at night			
Plays well with others			
Makes friends easily			
Difficulty with transitions			
Resists change in routine/ environment			
Sensory Concerns			If yes, a sensory form will be provided

Speech and Language Development:

Check all that apply .My child communicates by:

❑ Eye gaze ❑ Crying ❑ Gestures ❑ Sign language

❑ Single words ❑ Phrases ❑ Conversation ❑ Augmentative device

Describe Expressive/Verbal skills: _____

_____ _____

Can you understand your child's speech? ___Yes___No Can others? ___Yes___No

Estimate vocabulary size: ❑ 0 words ❑1-25 words ❑25-50 words ❑50-100 words ❑over 100 words

DescribeReceptive/Listening skills: _____

_____

Can your child follow directions? ___Yes___No

Can your child answer simple questions? ___Yes___No

Describe SOCIAL SKILLS: _____

_____

Feeding:

Does your child have feeding difficulties? ___Yes ___No
Would you like this to be addressed? ___Yes*___No *If yes, a feeding intake form will be provided.

Please provide any additional information that you think is important/relevant regarding your child's medical, social/emotional, and academic history: _____
_____
_____
_____
_____

Name of person who completed this form: _____
Relationship to child: _____

Signature: _____
Date:_____

If you have documentation related to your concerns please bring copies of records to your evaluation appointment. Thank you!