

**Pediatric Medical History Form**

Name of Child		Name of Parent/Legal Guardian:		SSN#
Address:		City:	State	Zip Code
Insurance Cardholder (if different)		Relationship to cardholder		Phone:
Address:		City:	State	Zip Code
Date of Birth	Age	Length of pregnancy	Sex <input type="checkbox"/> M <input type="checkbox"/> F	APGAR score at birth
Onset of Diagnosis	Referring Physician	Age of Siblings	Grade level	School Attending
If premature list cause if known:				
Note any complications at birth:				
Post Birth Status (oxygen, heart monitor)				
What equipment is used at home:				

Please check if your child has a history of any of the following

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Heart Problems                  | <input type="checkbox"/> Muscular disease     |
| <input type="checkbox"/> Circulation Problems            | <input type="checkbox"/> Lung Disease         |
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Nervous System Disease          | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Cardiac Pacemaker               | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Metal implants (rods, pins etc) | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Developmental Delay             | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Cerebral palsy                  | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Autism                          | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Serious Accident                | <input type="checkbox"/> Mental illness       |
| <input type="checkbox"/> Bone Fracture                   | <input type="checkbox"/> Other: _____         |

For Therapist Use Only

Do you feel your child has feeding difficulties?  Yes  No

During the past month has your child been more upset or distressed than normal?  Yes  No

During the past month has your child been less active or playful?  Yes  No

Are your child's immunizations up to date?  Yes  No

Please list any surgeries or hospitalizations your child has had (include dates if known): \_\_\_\_\_

\_\_\_\_\_

Please list any prescription or non prescription medications you child is taking \_\_\_\_\_

\_\_\_\_\_

Does your child have an established IEP from School?  yes  No

Is your child having difficulty in any of the following areas (please check all that apply)

- |                                       |                                     |                                   |
|---------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Feeding      | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Talking  |
| <input type="checkbox"/> Rolling over | <input type="checkbox"/> Sitting up | <input type="checkbox"/> Sitting  |
| <input type="checkbox"/> Crawling     | <input type="checkbox"/> Kneeling   | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Balancing    | <input type="checkbox"/> Walking    | <input type="checkbox"/> Running  |
| <input type="checkbox"/> Other: _____ |                                     |                                   |

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about my child by Jaworski Physical Therapy, Inc. for the purpose of treatment, obtaining payment for treatment and as necessary in order to carry out any healthcare operations that are permitted to the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use. By signing this Consent, I understand and acknowledge that I have reviewed the "Privacy Notice" which is attached before signing this Consent.

**General:** I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid to by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said payment benefits. The assignment will remain in effect until revoked by me in writing.

**Permission to take Photograph:** I hereby consent \_\_\_ or deny \_\_\_ Jaworski Physical Therapy, Inc. to take a photograph of my child only for the purpose to use in his/her medical chart and will not be disclosed for any other reason without additional permission from me.

\_\_\_\_\_  
Parent/Guardian signature if Minor

\_\_\_\_\_  
Date

## Professional Services

*Physical Therapy*  
*Occupation Therapy*  
*Hand Therapy*  
*Speech Therapy*  
*Pediatric Therapy*  
*Aquatic Therapy*  
*Pelvic Floor Rehab*  
*Athletic Training*  
*Social Service*

**JPT**  
aworski

137 Winckles St., Elyria, OH 44035  
Phone: 440-366-5993

1100 N. Abbe Rd., Elyria, OH 44035  
Phone: 440-365-2211

6150 Emerald St.  
N. Ridgeville, OH 44039  
Ph: 440-327-1602

**JPT**  
aworski

Jaworski Physical  
Therapy, Inc.

## Rehabilitation And Wellness Center

## New Patient Information

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Three Convenient Locations Serving  
Lorain and Surrounding Counties

[www. JPTRehab.com](http://www.JPTRehab.com)

# Welcome

Dear Patient,

We would like to welcome you to Jaworski Physical Therapy, Inc. and to thank you for selecting us to provide your therapy care. Our experienced and dedicated staff is committed to quality service and individualized attention.

Your initial evaluation will last approximately 1 to 1 1/2 hours. It will focus on the completion of a comprehensive evaluation and assessment of your condition. The data gathered will enable your therapist to provide a more individualized treatment plan and to communicate more effectively with your physician. After completion of your evaluation, a detailed report will be sent to your physician outlining our findings and plan of care.

Each additional visit will last anywhere from 30 - 45 minutes depending on your individual diagnosis and rehab program. We can provide you with our standard gowns or shorts, however if you would feel more comfortable in your own gym clothes, please feel free to wear them.

Prior to your initial visit, a member of our insurance office will contact your insurance company and verify your individual coverage. It is also recommended that you contact your insurance company to become familiar with your coverage for therapy. If by chance your insurance requires an authorization before initiating therapy, we will reschedule your initial visit until this authorization is received. At the time of your initial visit an explanation of your benefits will be given and you will be informed of any co-pays or deductibles required by you.



We have designed our office hours in hopes that they are most convenient for you. Our clinics have extended hours are on Monday, Wednesday and Thursday. In order to insure times that fit into your schedule we recommend that you keep your appointments scheduled two weeks in advance. Kindly provide 24 hours advance notice for any cancellations.

Please do not hesitate to contact us with any questions or concerns you may have. We look forward to seeing you!

Sincerely,

Jaworski Physical Therapy Staff

	137 Winckles St. Elyria, OH 44035 Phone: 440-366-5993 Fax: 440-366-5313 www.JPTR rehab.com	
	110 N. Abbe Road, Ste. C Elyria, OH 44035 Phone: 440-365-2211 Fax: 440-365-2299	6150 Emerald St. N. Ridgeville, OH 44039 Phone: 440-327-1602 Fax: 440-327-1656

## **Jaworski Physical Therapy, Inc.**

137 Winckles Street  
Elyria, Ohio 44035  
440-366-5993

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### **NOTICE OF PROTECTED HEALTH INFORMATION 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.

#### **Purpose of Notice**

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 42 CFR § 160.101 et seq. (the "Privacy Regulations"), Jaworski Physical Therapy, Inc. ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain. Should such terms change, we will mail a revised Notice to the mailing address most recently listed in your medical record.

#### **Permitted Uses and Disclosures of Your Health Information**

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, we are permitted with your written consent, to use and disclose your health information for the following purposes:
  - a. **Treatment.** We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

- b. **Payment.** We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record, which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.
        - c. **Health Care Operations.** We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.
2. **Uses and Disclosures With Patient Authorization.** Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.
3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.
4. **Uses and Disclosures Without Patient Consent, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:
  - a. **Uses and Disclosures Required by Law.** We will disclose your health information when required to do so by law.
  - b. **Public Health Activities.** We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.
  - c. **Abuse and Neglect.** We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

- d. **Regulatory Agencies.** We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.
- e. **Judicial and Administrative Proceedings.** We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, and warrant, discovery request or similar legal request.
- f. **Law Enforcement Purposes.** We may disclose your health information to law enforcement officials when required to do so by law.
- g. **Coroners, Medical Examiners, Funeral Directors.** We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.
- h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.
- i. **Threats to Health and Safety.** We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- j. **Military/Veterans.** If you are a member of the armed forces, we may disclose your health information as required by military command authorities.
- k. **Workers' Compensation.** We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
- l. **Marketing.** We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.
- m. **Appointment Reminders.** We may use and disclose your health information to remind you of an appointment for treatment and medical care at our clinic.

- n. **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.
5. **Uses and Disclosures to Business Associates.** With the proper consent or authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity, which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

## Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request. If, however, we agree to the requested restriction, it is binding on us.
2. **Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.
3. **Right to Verbally Object.** You have the right to verbally object to certain disclosures that are routinely made without any Consent or Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.
4. **Right to Seek an Amendment of Your Health Information.** You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information.** You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures to you based on your consent, authorization or other means permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to our compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.
6. **Right to Confidential Communications.** You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.
7. **Right to Revoke Your consent and/or Authorization.** You have the right to revoke your consent or authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.
8. **Right to Receive Copy of this Notice.** You have the right to receive a copy of this Notice.