Cynthia Miles & Associates LLC.

Date

Child's Full Name Birth Date

Home Address City State Zip Code

Child's Social Security # Home Phone #

Mother's Full Name Birth Date

Home Address City State Zip Code

Mother's Social Security # Home Phone #

Work Phone # Cell Phone # Email

Employer's Name & Address

Father's Full Name Birth Date

Home Address City State Zip Code

Father's Social Security # Home Phone #

Work Phone # Cell Phone # Email

Employer's Name & Address

Emergency Contact Name Home Phone # Cell Phone #

Referring Physician Physician's Phone

Reason for Referral Diagnosis

Physician Family Physician Phone #

Orthopedist Neurologist

Allergies

Surgical / Illness History

Other Programs and Related Services

Siblings Name / Age

Cynthia Miles & Associates LLC.

Current Patient Information:

Gender: **M/ F** Ethnic Origin:_____Current Weight:_____ Length: _____

Height/Weight Percentile:_____ Length of Hospital Stay: _____ Apgars:_____ Birth Order: _____

Weight at Birth: _____ Length at Birth: _____ Head Circumference:_____

Gestational Age: _____Was child born prematurely? **Yes / No** If yes: Chronological Age:_____

Mom's age at time of birth: _____

Name of Hospital Child Born:_____

Name of Birth Center:_____

Ob/Gyn &/or Mid-Wife: _____

Was your child admitted to NICU or did he/she remain in newborn nursery?_____

Did your child receive therapy services prior to returning home (in NICU, PICU, or nursery)? **Yes / No**_____

Utero Position:_____ Attendance at a Pre-Natal Class: **Yes** / **No** Was infant active? **Yes / No**

Infant Position at birth: Vertex / Breech / Transverse / Other:_____

How long in Labor_____ How long did you push?_____

Delivery: Vaginal / C-Section / Forceps / Vacuum / Nuchal Cord / Other:_____

Did the infant seem stuck in one position for the last part of pregnancy? **Yes / No** _____

How many weeks was the infant stuck? Vertex / Breech / Transverse _____weeks

First Child? **Yes / No** **Single / Multiple Birth**: Twin A / Twin B

List any complications during pregnancy (bed rest/low back pain/ leg pain):_____

_____

List any complications during delivery:_____

_____

List any medications taken by mother during pregnancy & delivery:_____

List of child's medications, including vitamins _____

Has child ever been treated for torticollis? Yes/No _____

Has child ever been treated for any other diagnosis Yes/No If yes please name_____

Know Uterine Abnormalities? **Yes / No** Describe:_____Fertility Treatment: **Yes / No** Medication:_____

Diagnostic Test: **X-Ray** **MRI** **CT Scan** **US**

SWALLOWING STUDY **VISION EXAM**

If applicable, does your child snore? **Yes / No** Does your child have frequent ear infections? **Yes / No**

Please list the age of child at the following milestones (in months):

Started crawling:____Started walking:_____Started talking:_____Eating Table Food_____
Mouthing of toys/hands:____ Cereal introduced:____ Pacifier use:_____

Current Patient Information:

Was child breastfed? **Yes / No** Length of Time _____

Did your infant have trouble feeding? **Yes / No** (breast: left / right; bottle feeding)

Jaundice? **Yes / No** Reflux? **Yes / No** Medication:_____

What kind of food/formula does your child eat?_____

Does child have sensitivities? Yes/no If yes_____(ie, sounds, textures,etc.)

How does your child typically communicate? **Circle one**: gestures / single words / short phrases / sentences

Is your child understood by others or just family members?_____

Where do you generally seek information on your child's development? _____

_____

Did your infant have a normal head shape at birth? **Yes / No** If no, describe:_____
Who noticed misshapen head?_____ What age?_____

Time child spends in car seat carrier per day:_____ Type used:_____

Time child spend in swing per day:_____

Other infant sitting devices used and time spend per day:_____

_____

Child's Mealtime Position: highchair___ booster seat___ car seat___ bumbo____ other____
Child's Sleep Position (birth-1 yr): Supine (on back) __Side __Prone (on tummy) ___Other:_____
Explain

Time child spends on back daily:_____Time child spends on belly daily:_____

Belly increments per day_____ Age Initiated Belly Time_____

How often is baby held_____ What position _____

Does your infant have a head tilt preference: **Left / Right** Rotation Preference: **Left / Right**

Any other children with tight neck muscles and / or misshapen head? **Yes / No**

Do you notice any facial asymmetry? **Yes / No** Describe:_____

Congenital anomalies:

Hip dysplasia / hip subluxation left / right

Fractured clavicle left / right

Forceps abrasion left / right

Facial palsy left / right

Brachial plexus injury left / right

Cephalohematoma: Parietal left/ right, small / medium / large

Occipital left / right, small / medium /large

Cynthia Miles & Associates LLC.

Emergency Treatment Permission

I give my permission for a staff member of Cynthia Miles & Associates to take me and/or my child to a Hospital Emergency Room for me and/or my child's Treatment if the need for Emergency Care arises. I hereby give my permission for the staff member to respond by activating EMS (Dialing 911), Initiating Rescue Breathing and/or Basic CPR Procedures and/or Basic First Aid if appropriate. I therefore accept full responsibility for whatever consequences may occur and hold Cynthia Miles & Associates, LLC. to **NO** Legal or Medical Liabilities.

Signed:_____ Date:_____

Child's Name:_____

**********OR**********

I have read the above stated emergency permission statement and **DO NOT** grant staff members of Cynthia Miles & Associates permission to initiate Basic Emergency Procedures in the event that a staff member would be present during a medical emergency in which I, myself, was unable to perform necessary Emergency Procedures. I therefore accept FULL Responsibility for whatever consequences may occur and Hold Cynthia Miles & Associates, LLC to **NO** Legal or Medical Liabilities.

Signed:_____ Date:_____

Child's Name: _____

****

*Special Instruction or Restrictions:_____

_____

_____

Consent to Obtain or Release Information

I authorize Cynthia Miles & Associates to obtain or release information regarding my son/daughter

_____ Date of Birth:_____

This information exchange is of the purpose of providing Physical, Occupational, Speech Therapy and/or Special Instruction Programs which will meet the needs of my child. This includes providing treatment, procuring payment and conducting health care operations. I understand that in order to protect confidentiality of records, my agreement to obtain or release information is necessary. The information will only be shared as necessary to provide quality treatment and communication between your primary Health Care, Educational, and Payment Providers. I understand that by written statement, to Cynthia Miles & Associates, I may withdraw my permission at any time.

This consent will be in effect throughout the duration of my child's treatment regime. It is effective for all Physical, Occupational, Speech Therapists and teachers at Cynthia Miles & Associates who treat and/or have contact with my child.

Please be advised we make every effort to maintain strict confidentiality for all of our clients. However, due to our open concept design, information about your child may be overheard.

Permission to Photograph your child:	Yes_____	No_____
Permission to display photograph of your child:	Yes_____	No_____
Permission to video tape your child:	Yes_____	No_____
Permission to display photograph of your child in our Brochure:	Yes_____	No_____
Permission to display photograph of your child on our web site:	Yes_____	No_____
Permission to use child's information in research study:	Yes_____	No_____

Parent/Guardian_____ Date:_____

OPTIONAL: This release of information or ability to obtain information is Limited to the following:

_____

_____

HOME POLICY AND INFORMATION

CLIENT CANCELLATION POLICY:

We realize that in the world of children and busy families, cancellations are sometimes inevitable. With this in mind, we ask that when cancellation of your child's physical, occupational, speech therapy or special instruction appointment is absolutely necessary you give us a call as far in advance as possible. 24-hour notice is preferred but considerations for sudden illness will be made. We are happy to re-schedule missed appointments if possible, but please understand that most of our schedules are quite full and availability of make-up times may be very limited.

Unfortunately, due to our leniency and abuse of "NO-SHOWS" in the past, we find it necessary to hold the following "NO-SHOWS" Policy. The first appointment which is missed without notification of cancellation to our office by the time of the appointment will result in a phone call to remind you of the missed appointment and to re-schedule, if possible. The third missed appointment without notification to our office will result in termination of services for your child. Of course, special emergency circumstances will be considered.

We believe that your commitment to your child's therapy schedule is essential to his or her progress and ultimate development. We thank you in advance for your cooperation in this matter. Helping your child to reach his or her maximum potential is both our privilege and pleasure.

THERAPY SESSIONS:

HOME VISITS: Please keep in mind therapy sessions are usually scheduled for one hour time periods. Please take into consideration that the therapist could be a few minutes early or late due to traffic conditions, which are beyond their control. If you have any questions to discuss with your therapist, please do so during their session as in most cases they must leave to travel to another visit. Also, keep in mind therapists take their toy bags from home to home. Many of their clients are medically fragile and therefore are allergic to smoke and/or pet dander. Please refrain from smoking in their presence and keep pets away.

SIBLING POLICY:

HOME VISITS: We ask that parents supervise all siblings so they do not disrupt your child's therapy session. Your cooperation in this matter is greatly appreciated.

Cynthia Miles & Associates LLC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper , or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information a how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:
- Treatment
- Payment
- Healthcare Operations

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you , to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

~**Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example would be: the treating therapist or teacher sends written paper work which may include evaluations, client notes, letters, treatment plans to your referring physician or referral sources. This may also include the above paperwork being sent to your insurance company or payment provider and may include our Office Staff filing your paperwork and taking care of the mailing.

~Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment, this may include but not be limited to treatment plans, clients notes, evaluations and letters.

~Healthcare Operations means we may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. The activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to physical therapy students that see clients in our office. We may call you by name in the waiting room when it is time for your appointment. We may use your protected health information, as necessary, to contact you to remind of your appointment.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. This contact may be by phone, mail, fax, or email.

Any other disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the office staff of Cindy Miles and Associates:

~ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

~ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

~ The right to inspect and copy your protected health information. We have the right to charge for this information.

~ The right to amend your protected health information.

~ The right to receive accounting disclosures of protected health information.

~ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of_____, 20___and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notices of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post this notices and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice of the policies and procedures of our office.. We will not retaliate against you for filing a complaint.

Signature:_____ Date:_____