PROGRESSIVE BEGINNINGS
920-803-1617 Rehabilitation Specialists

2131 S Business Drive Sheboygan, WI 53081
P: (920) 803-1617 F: (920) 803-1622

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, MI):_____

Sex: M F DOB (mm/dd/yyyy): _____ Social Sec Num:_____/_____/_____

Address:_____ City:_____ State:_____ ZIP:_____

Phone: (___)_____ EMAIL:_____

Would you like reminders of upcoming appointments? Circle one: TEXT or EMAIL

RESPONSIBLE PARTY IF OTHER THAN SELF:

Name (Last, First, MI):_____Relationship to patient:_____

Sex: M F DOB (mm/dd/yyyy): _____ Social Sec Num:_____/_____/_____

Address:_____ City:_____ State:_____ ZIP:_____
(If same as patient as patient leave blank)

Phone: (___)_____ EMAIL:_____

Name (Last, First, MI):_____Relationship to patient:_____

Sex: M F DOB (mm/dd/yyyy): _____ Social Sec Num:_____/_____/_____

Address:_____ City:_____ State:_____ ZIP:_____
(If same as patient as patient leave blank)

Phone: (___)_____ EMAIL:_____

OTHER CONTACT INFORMATION

Other Doctor/Clinic:_____ Phone:_____

School:_____ Phone:_____

Social Worker: _____ Phone:_____

GENERAL HISTORY

General concerns: _____

What are your goals for therapy? _____

Please list any services that your child is currently receiving: _____

_____

Has your child had a recent vision examination? Yes / No Results? _____
Has your child had a recent hearing examination? Yes / No Results? _____
Has your child had any evaluations by a medical or educational specialist? Yes / No Results? _____

PROGRESSIVE BEGINNINGS
920-803-1617 Rehabilitation Specialists

2131 S Business Drive Sheboygan, WI 53081
P: (920) 803-1617 F: (920) 803-1622

PATIENT REGISTRATION FORM

MEDICAL HISTORY

PREGNANCY AND BIRTH HISTORY

❑ Full term ❑ Premature (_____) weeks of gestation Birth Weight: _____ lbs _____ oz

Were there any extraordinary conditions before, during, and after the birth? For example: high fever, measles, use of drugs, alcohol, or prescription medicines. Please explain:

_____

_____

HEALTH HISTORY
Does your child now have or ever had any of the following:

Illnesses at birth (List:_____)	Yes / No
Allergies (to what _____)	Yes / No
Asthma	Yes / No
Seizures	Yes / No
Hospitalizations (When?_____)	Yes / No
Surgeries (For what and when? _____)	Yes / No
Ear Infections (When?_____)	Yes / No
Other: _____	Yes / No

Please list any *medications* that your child is takinG: _____

_____

DEVELOPMENTAL HISTORY
When did your child begin to:

Sit alone? _____ Crawl? _____
Pull to stand? _____ Walk? _____
Say 1st words? _____ What were they? _____
Put two words together? _____ What were they? _____
Finish toilet raining? _____

PROGRESSIVE BEGINNINGS
920-803-1617 Rehabilitation Specialists

2131 S Business Drive Sheboygan, WI 53081
P: (920) 803-1617 F: (920) 803-1622

Please place an 'X' in the appropriate box that describes how much assistance your child needs with each activity below:

	TOTAL ASSIST (NEEDS 100% HELP)	MAX ASSIST (NEEDS 75-100% HELP)	MODERATE ASSIST (NEEDS 50-75% HELP)	MINIMUM ASSIST (NEEDS 25-50% HELP)	INDEPENDENT (0% HELP)
PUT ON SHIRT					
PUT ON PANTS					
PUT ON SOCKS					
PUT ON SHOES					
TAKE OFF SHIRT					
TAKE OFF PANTS					
TAKE OFF SOCKS					
TAKE OFF SHOES					
COMPLETE BUTTONS					
COMPLETE ZIPPERS					
COMPLETE SNAPS					
COMPLETE BUCKLES					
TIE SHOES					
BRUSH TEETH					
BATHING					
BRUSH HAIR					
FINGER FEEDING					
UTENSIL USAGE					
DRINKING OPEN CUP					

PROGRESSIVE BEGINNINGS
920-803-1617 Rehabilitation Specialists

2131 S Business Drive Sheboygan, WI 53081
P: (920) 803-1617 F: (920) 803-1622

PATIENT SERVICES AGREEMENT

PATIENT NAME:_____ **DOB:**_____/_____/_____

Please initial each policy demonstrating your understanding and consent.

1. ___I authorize Progressive Beginnings, LLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Progressive Beginnings, LLC. I authorize Progressive Beginnings, LLC to release medical or other information necessary to process claims. I agree to pay my deductible, coinsurance or copayment, and any charges not reimbursed by my insurance carrier. **All copayments are due at the time of service.** Outstanding amounts, including deductibles are payable and due within 30 days of receipt.

2. ___It is the patient's responsibility to inform Progressive Beginnings, LLC of any and all changes in insurance information or coverage. Failure to do so could result in the patient being 100% responsible for all therapy charges.

3. ___If an emergency should occur during treatment, we will contact 911, Sheboygan Pediatric Associates, and the patients primary medical doctor, unless a certified copy of a DNR order has been given to Progressive Beginnings, LLC

4. **___HEALTH POLICY: If the patient is sick and/or contagious within 24 hours of a scheduled appointment, please stay home and do not bring the potential infection into the clinic.**

5. **___**I have been offered or received the NOTICE OF PRIVACY PRACTICES from PROGRESSIVE BEGINNINGS, LLC.

6. **___CANCELATION POLICY:** An agreement has been made between therapist and patient as to the frequency of rehabilitation services in order to maximize the therapeutic effect of treatment. If an appointment must be canceled, we request you call Progressive Beginnings **at least 24 hours** prior. **After 3 CANCELATIONS, the patient will be placed on a schedule-based-on-availability list. This will require the *patient to call for an appointment on each day* he/she would like to receive therapy. We will do everything possible to accommodate you as space on the schedule permits.**

7. **___ NO SHOW POLICY:** TWO consecutive NO SHOWS will result in the cancelation of all remaining scheduled appointments and patient will be discharged.

For our pediatric patients (adults may leave section below blank):

1. ___It is a courtesy of Progressive Beginnings, LLC to allow parents/legal guardians to leave the premises during the appointment of a minor child. If leaving the premises, you must have a contact cell phone on file. You must return to the premises no later than 10 minutes prior to the scheduled end of your child's therapy session.

2. ___Children cannot be left unattended in the waiting room. All children and guardians must wait in the reception area until a therapist has arrived to start the session. Children are also not permitted to wait outside for their ride to arrive.

PATIENT/GUARDIAN SIGNATURE: _____ **Date:**_____/____/_____

LICENSED THERAPIST: _____ **Date:**_____/____/_____

PROGRESSIVE BEGINNINGS
920-803-1617 Rehabilitation Specialists

2131 S Business Drive Sheboygan, WI 53081
P: (920) 803-1617 F: (920) 803-1622

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH CARE INFORMATION

PERSON WHOSE INFORMATION IS AUTHORIZED TO BE USESD OR DISCLOSED:

Name (Last, First, MI): _____

Sex: M F **DOB (mm/dd/yyyy):** _____ **Social Sec Num:**_____/_____/_____

Person or entity authorized to use or disclose information NAME:_____ ORGANIZATION:_____ ADDRESS:_____ City/State/Zip:_____	**Person or entity authorized to use or disclose information** **PROGRESSIVE BEGINNINGS, LLC** **2131 S BUSINESS DRIVE** **SHEBOYGAN, WI 53081** **(920) 803-1617**
Person or entity authorized to use or disclose information **PROGRESSIVE BEGINNINGS, LLC** **2131 S BUSINESS DRIVE** **SHEBOYGAN, WI 53081** **(920) 803-1617**	Person or entity authorized to use or disclose information NAME:_____ ORGANIZATION:_____ ADDRESS:_____ City/State/Zip:_____

I authorize the following information to be used or disclosed:	**Reason or Purpose for use or Disclosure (Check all that Apply):**
___Therapy Evaluations ___Medical Evaluations/Physical Exams ___Progress Notes/Staffing Notes/Daily Notes ___Discharge Summary __ School Academic Records/IEP/IFSP __ Other (specify) _____	___ At my Request ___ Further Medical Care ___Coordination of Services __ Other (Specify): _____

AUTHORIZATION

- This authorization is good for one calendar year from the date signed below
- I understand that if I refuse to sign, this will not interfere with my treatment or eligibility.
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws
- I have read this form and understand the contents contained within. I agree that a photocopy or facsimile of this form is as valid as the original. This form accurately reflects my wishes and I authorize the use and disclosure of the information described on this form
- I am (check one) _____the person _____the authorized representative of the person, whose information is authorized to be used or disclosed.

SIGNATURE:_____ **Date:**_____/_____/_____

If signed by person other than client, state name and relationship:

Name:_____ **Relationship to Client:**_____