PROGRESSIVE BEGINNINGS
Rehabilitation Specialists

1125 N 13th Street 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 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 leave blank)

Phone: (___)_____________________ EMAIL:____

GENERAL HISTORY

General concerns: ____

____

What are your goals for therapy? ____

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? ______________________________

Please list any other services that your child is currently receiving (ABA, counseling, etc) _________________

____

SCHOOL HISTORY

What school does your child attend? ____

Grade: _______ Teacher: ____________________________________ Phone:_________________

Does your child have an IFSP or IEP? Yes / No What services does your child receive? OT PT ST Special Ed

Social Worker (if applicable): ____ Phone:_________________

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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
Medical Diagnoses (Include date of diagnosis)____ ____	Yes / No
Other: ____	Yes / No

Please list any *medications* that your child is taking: ____
____

DEVELOPMENTAL HISTORY
When did your child begin to:

Sit alone?	______________________	Say 1st sounds?	______________________
Pull to stand?	______________________	What were they?	______________________
Crawl?	______________________	Say 1st words?	______________________
Walk?	______________________	What were they?	______________________
Finish toilet raining?	____________________	Put 2 words together?	______________________
		What were they?	______________________

How does your child currently communicate? Please give examples of their speech/language skills, non-verbal communication/gestures, etc. ____

FEEDING HISTORY
Any history of feeding difficulties? **Yes / No** If yes, describe ____

Describe your child's current eating habits and typical intake: ____

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PATIENT SERVICES AGREEMENT

PATIENT NAME:____ **DOB:**________________

By signing below I am demonstrating understanding and consent for the following:

- **FINANCIAL POLICY:**
  - 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 understand that I am ultimately responsible for my therapy charges , and I agree to pay my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment or have reimbursement limits on therapy limits. I understanding that I am responsible for knowing and meeting the requirements of my insurance plan.
  - I understand that **all copayments and co-insurances are due at the time of service**. Outstanding amounts, including deductibles are payable and due within 30 days of receipt.
  - 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.

- **HEALTH POLICY:**
  - If an emergency should occur during treatment, we will contact 911.
  - CPR will be initiated, unless the patient has provided a certified copy of DNR order to Progressive Beginnings, LLC.

- **HIPAA POLICY:**
  - We are required by federal and state laws to maintain the privacy of your/ your child's 'Protected Health Information', PHI. Your signature below indicates you have been offered or received a copy of the 'Notice of Privacy Practices and Your Rights', which describes how health care information about you or your child may be collected, used and disclosed for purposes of treatment or payment or for other specified purposes that are permitted and required by law.

Patient/Guardian Signature		Date	

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CANCELLATIONS AND NO SHOWS

PATIENT NAME:____ **DOB:**_________________

Progressive Beginnings strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to meeting goals and required for your insurance company to reimburse for the service.

- We require a **24 hour notice** in the event of a cancellation. We request that you have an alternative time in mind when canceling so that we can ensure you or your child gets in the full prescribed number of treatments that week whenever possible.

- All rescheduling of appointments can be completed by communicating directly with your therapist or by calling the front desk.

- If you have > 2 cancels in 8 weeks without rescheduling we will be required to move you to a **flexible schedule.** This will require scheduling within the current week, based on our therapist's availability. We will do everything possible to accommodate space on the schedule, however understand that the appointment may not be with the therapist that normally provides your treatment, and may not be at your preferred time. Once consistency and frequency with attendance improves for 4 consecutive weeks you may earn a reserved time back.

- If you or your child are experiencing any illness symptoms which you feel may be contagious, please call the front desk and request your visit be converted to a Telehealth visit.

- Failure to show up for an appointment **(“NO SHOW”)** without notifying us will result in the cancellation of all remaining scheduled appointments.

Patient/Guardian Signature		Date	
Therapist Signature		Date	

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CONSENT TO PHOTOGRAPH

PATIENT NAME:____ **DOB:**_________________

(CHECK ONE)

❏ I hereby give my consent to Progressive Beginnings to use my photograph(s), information, and/or video related to my experiences with Progressive Beginnings. I understand this information may be used in publications, presentations, promotional material, advertising, social media, displayed in office, and/or similar ways. I understand that I may revoke this authorization at any time by notifying Progressive Beginnings, LLC in writing. The revocation will not affect any actions taken before the receipt of this written notification.

❏ I do NOT give my consent to Progressive Beginnings to use my photograph(s), information and/or video related to my experiences with Progressive Beginnings.

Patient/Guardian Signature		Date	

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ADL CHART

PATIENT NAME:____ **DOB:**________________

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					