Patient Name: West Texas Rehabilitation Center
DOB: Medical Record# Date:

CONSENT FOR TREATMENT

I, the undersigned, am the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and do hereby voluntarily consent to and authorize West Texas Rehabilitation Center, Inc., (WTRC), a Texas non-profit corporation, or other related entities to administer treatment as per the doctor's orders.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION OF RELEASE OF INFORMATION

I hereby assign to WTRC all benefits provided under any healthcare plan, medical policy, motor vehicle insurance and/or any other entities paying on my behalf, otherwise due or payable to me provided the amount of such benefits shall not exceed the amount of said professional service charges. I understand that I am personally responsible to WTRC for all charges not covered by this assignment and that a photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any records/information, including papers, forms, videos, photographs and other records pertinent to my case, to any insurance company, adjuster, medical case manager, employer, physician or other medical entity, or attorney involved in the case.

PAYMENT POLICIES

1. Although you may be assisted by private insurance, Worker's Compensation, Medicare, Medicaid or even WTRC's Donor Sponsorship Program, payment for services received by you or your family is ultimately your responsibility. Cash, personal checks and major credit/debit cards are accepted.
2. Payment is required at the time of service if you have an insurance plan that dictates a per visit co-payment. Patients who do not have such a feature in their insurance coverage will be mailed a statement indicating their financial responsibility for the services provided.
3. WTRC is committed to assisting families with their financial responsibilities. The Donor Sponsorship Program is designed to identify families with various levels of need and provide them with corresponding assistance. Our staff will be glad to assist you in determining your eligibility for assistance. Before this process can begin; however, we need to know that you would like to seek assistance and are willing to provide the needed information.

WTRC hopes that this information helps to clarify our policy. If at any time you have a question or you would like to be reconsidered for sponsorship based on new information, do not hesitate to ask the Admissions staff.

THIRD PARTY DISCLOSURES I, _____, am the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and give the following person(s) or representative(s) permission to discuss appointments, medical treatments and/or any financial matters on my behalf and request copies of medical records.

_____ _____
Printed Name Relation (Phone) Printed Name Relation (Phone)

Please circle "yes" or "no":

Y N I grant permission for WTRC personnel to leave messages on my home voice mail and/or cell phone.
Y N I grant permission for WTRC personnel to send me text messages on my cell phone.
Y N I grant permission for WTRC personnel to leave messages on my work voice mail, if applicable.
Y N I grant permission for WTRC to communicate via email. If Yes, Email: _____
Y N I grant permission for WTRC personnel to contact me for fundraising efforts.
Y N I grant permission for WTRC to use my name and/or image in marketing materials as outlined in the Media Release in the orientation packet.

I have been offered a copy of the appropriate orientation to West Texas Rehabilitation Center. I have been offered a copy of "Your Information. Your Rights. Our Responsibilities.", which describes how medical information about you may be used and disclosed and how you can get access to this information. If after reviewing the document, should you have any questions, our Admissions staff would be glad to answer them.

_____ _____
Signature of Patient or Guardian Date WTRC Witness Date

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PEDIATRIC MEDICAL/SOCIAL HISTORY

1. When was the last time the child was seen by a doctor?

2. What is the child's primary problem/concern that brings the child to West Texas Rehab?

3. How long has this problem been noticed?

4. How did this problem start?

❑ Result of specific injury/trauma ❑ Gradually ❑ Other (please explain)

5. Please indicate agencies below that are providing services for the child for health problems?

❑ECI ❑School District/Co-op ❑Private Therapist ❑Home Health (for Therapy Only) ❑Other (explain on back)

6. What is the primary goal for this child in therapy? What is the main area in need of improvement?

7. Has this child been treated at West Texas Rehab for anything before? ❑ Yes (explain below) ❑ No

If yes, when and for what?

8. Has this child been in the hospital? ❑ Yes (please explain below) ❑ No

Hospital	Dates	Reason

9. Below, please list the child's medications, which doctor is prescribing and that doctor's phone number.

❑ No Medications Currently ❑ See Attached List ❑ I do not remember and will bring a list with me next time.

Medication	Prescribing Physician	Physician's Phone Number

10. Is this child allergic to any medications or foods? ❑ Yes (please list them below) ❑ No

For the following conditions, make a mark under the "P" if the child had this condition in the PAST or a mark under the "C" if the child CURRENTLY has the condition or the results of the condition.

P	C		P	C		P	C		P	C	
❑	❑	Asthma	❑	❑	Hearing Problems	❑	❑	Sensory Integration Disorder	❑	❑	Prematurity
❑	❑	Lupus	❑	❑	Vision Problems	❑	❑	Traumatic Brain Injury	❑	❑	Other (explain)
❑	❑	Diabetes	❑	❑	Chronic Bronchitis	❑	❑	Learning Disability			
❑	❑	Heart Disease	❑	❑	Bone Fracture	❑	❑	Muscular Disease			
❑	❑	Paralysis	❑	❑	Chronic Pain	❑	❑	Developmental Delay			
❑	❑	Stroke	❑	❑	Seizure Disorder	❑	❑	Orthopedic Problems			
❑	❑	ADD/ADHD	❑	❑	Ear Infection	❑	❑	Gastroesophageal Reflux (GERD)			

Where does the child spend most of his/her day?

❑ Home
❑ Day Care
❑ School
❑ Other (please explain)

Which of the following financial resources does the child's family have at this time?

❑ Employment ❑ CHIP
❑ Medicaid ❑ CSHCN (CIDC)
❑ Insurance ❑ Supplemental Security Income (SSI)
❑ Pension ❑ No Income
❑ Other (please explain)

All Languages spoken in the home, mark ALL that apply:

❑ English ❑ Spanish ❑ French ❑ German ❑ Other: _____ (specify)

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Are there problems with transportation? ❑ Yes (explain) ❑ No

Who lives in the child's home now?

Which of the following equipment does the child currently use?

❑ Oxygen
❑ Wheelchair
❑ Wheelchair Ramp
❑ Walker/Rolling Walker
❑ Crutches/Cane
❑ Hospital Bed
❑ Nebulizer
❑ Shower Bars
❑ Shower Chair/Bench
❑ Ventilator
❑ None
❑ Other (please explain)

What other equipment do you think the child might need?

Which of the following people help the child the most? *(check all that apply)*

❑ Parents
❑ Friends/Neighbors
❑ Brother/Sister
❑ Other (list below)
❑ Church Friends
❑ Co-workers
❑ Other Agency
❑ No one

Do these people need some extra help in order to meet the child's needs?
❑ Yes ❑ No ❑ Unsure

Is there anyone else with special needs in the child's home? ❑ Yes (please list them below) ❑ No

Please describe the mother's general health during the pregnancy, labor and delivery below.

Length of pregnancy:

Child's birth weight:

Please write the approximate age of the child when they began doing each of the following activities:

Crawling:		Feeding self:		Combining words:	
Walking:		Standing:		Naming simple objects:	
Using Toilet:		Dressing self:		Using simple questions:	
Sitting alone:		Using single words:		Engaging in conversation:	

Has the child ever had any feeding problems (sucking, swallowing, drooling, chewing, etc…)?* ❑ Yes ❑ No

**If yes, describe.*_____

1. Has the child lost weight within the last 3 months? ❑Yes ❑ No
2. Has the child had unexpected weight changes over the last 3 months? ❑Yes ❑ No
3. Has the child been eating/feeding less than usual with in the last 2 weeks? ❑Yes ❑ No

Please mark the appropriate box below that describes the child's response to sound:

❑ Responds to all sounds ❑ Responds ONLY to loud sounds ❑ Inconsistently responds to sounds

For each of the following activities, please place a mark if the child is limited in or has difficulty doing them.

❑ Bathing
❑ Dressing – Upper Body
❑ Dressing – Lower Body
❑ Eating ☐ fruits ☐ vegetables ☐ meat/protein
❑ Hand Dominance ☐ L ☐ R ☐ not established
❑ Swallowing
❑ Grooming
❑ Walking ❑ Indoors ❑ Outdoors
❑ Standing ❑ Under 15 mins ❑ Over 15 mins
❑ Lifting ❑ Waist Level ❑ Overhead
❑ Sitting ❑ Under 15 mins ❑ Over 15 mins
❑ Sleeping ❑ On their back ❑ On their stomach ❑ On their left side ❑ On their right side
❑ Climbing
❑ Sitting Alone
❑ Toileting
❑ Stairs
❑ Speaking
❑ Hearing
❑ Problem Solving
❑ Other (please explain)

Do you currently have an Advanced Directive or Universal Do-Not-Resuscitate Order?* ❑ Yes ❑ No

**If yes, please provide a copy for our records.*

Name of person that completed this form: (please print)

Signature of person that completed this form:

Relation to patient:

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PEDIATRICS ATTENDANCE POLICY

At the time of your child's evaluation, the therapist will discuss with you the recommendations for how often the child will be seen for therapy. Please notify the therapist at the time of the evaluation of any special requests you may have for appointment scheduling (or at any time if a schedule change is needed). Please understand that we will do our best to accommodate your needs, but it is not always possible to meet every special request.

You will be expected to attend all of the scheduled appointments and sign in at the secretary's desk. If your child will be unable to attend therapy for any reason, please call the secretary within 24 hours of the scheduled appointment, or as soon as possible.

Abilene: 325-793-3452
San Angelo: 325-223-6320

Two or more absences without prior notice will result in discharge, and your child's physician will be notified.

Additionally, frequent absences (even those reported in advance) have a negative effect on your child reaching their treatment goals.

In cases of frequent absences (attendance rate of less than 50%), your child will be discharged and their physician will be notified.

Note: If you wait longer than 5 minutes past your appointment time, please let us know. Our goal is to increase your child's overall function at home, at school and in the community. Please make your therapist aware of your child's next doctor's appointment so that we can submit updated information about your child's status.

Patient's Printed Name	Patient/Guardian
Date	Witness Signature

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DEMOGRAPHICS UPDATE

****** Please Print ******

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: *M* *F* *(Please circle)*

Emergency Contact: _____
(Name) ***(Relation)*** ***(Phone)***

Form Completed By: _____ Relation: _____
(Signature)

Parent/Guardian's Name(*s*) (*If Minor*): _____
(Name) ***(Relation)***

PRIMARY INSURANCE INFORMATION

Company: _____ **Phone Number: _____**

Policy Holder: _____ **Relation: _____ DOB: _____**

Policy #: _____ **Group #: _____**

SECONDARY INSURANCE INFORMATION

Company: _____ **Phone Number: _____**

Policy Holder: _____ **Relation: _____ DOB: _____**

Policy #: _____ **Group #: _____**

WORK COMP/LIABILITY/AUTO ACCIDENT

Employer: _____ **Adjuster's Name: _____**

Date of Injury/Accident: _____ **Adjuster's Phone #: _____**

Claim Number: _____ **Legal Rep: YES NO Police Report: YES NO**

Auto Insurance: _____ **Legal Rep Name: _____**

For WTRC Staff Only

☐ **Picture ID of Parent/Guardian** ☐ **Copy of Current Insurance**

Received by: _____ Date: _____