Jupiter Medical Center
Jupiter, FL. 33458

PEDIATRIC REHABILITATION SERVICES
THERAPY CASE HISTORY

The information requested below will help us better understand your child and to develop an effective treatment plan. Please complete as much as you can. Thank you.

Child's Name: _____ Date of Birth: _____ Sex: _____

Child resides at: _____

Telephone (H) _____ (W) _____ Age: _____

Person completing form: _____ Relationship: _____

Address: _____ Phone: _____

Referred by: _____ Physician: _____

Previous testing by: _____ When? _____

Name of Child's Primary Physician: _____ Preferred Hospital: _____

(Please forward results to this office)

Please explain what brings you to this center today:

_____

_____

_____

_____

Family History

List all those living in the home:

Name:	Age:	Relationship:	Speech/hearing problem:

Languages spoken in the home? _____

Birth History *(Check all that apply).*

This is our: ❑ biological ❑ foster ❑ adopted child.

Age of mother at pregnancy _____

Any of the following during pregnancy?

❑ German measles ❑ toxemia ❑ accidents, injuries ❑ kidney infection ❑ anemia

Please describe, including medical attention: _____

Pregnancy was ❑ full term ❑ premature Number of months: _____

Delivery was ❑ normal ❑ caesarea ❑ breech ❑ forceps

Length of hard labor: _____ Medication: _____

Any additional comments/information:

_____

_____

_____

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Child's Name:_____

Birth weight:_____ Any birth injuries? ❑ No ❑ Yes (describe)_____

Was your child: ❑ RH baby ❑ jaundiced ❑ required oxygen

Any special medications or treatment at birth? _____

Was your child: ❑ bottle fed ❑ breast fed; how long? _____

Any feeding problems? ❑ No ❑ Yes; describe: _____

Medical History: Are immunizations current?_____ Child's Wt._____ Ht._____

Does the child have a history of *(if yes, please indicate age and check level of severity)*

	No	Yes	Age	Mild	Moderate	Severe
Allergies						
Asthma						
Chicken Pox						
Dental Problems						
Ear Infections*						
Encephalitis						
Head Injury						
High Fevers						
Measles						
Meningitis						
Mouth Breather						
Tonsillitis						
Upper Respiratory Infections						

* If child has history of ear infections, please indicate age of first infection_____ How often?
Last infection?_____ Treatments_____

Is child being seen by an ear, nose and throat physician? ❑ No ❑ Yes

Has child's hearing been tested? ❑No ❑ Yes; when?_____ By whom?_____

Results: _____

Describe any other illness accidents or injuries or hospitalizations, including age and length of stay:

_____

_____

Is child currently under medical treatment or taking any medication? ❑No ❑ Yes - Please describe:

_____

_____

_____

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Child's Name: _____

Developmental History

Sat alone at _____ months. Fed self at _____ months. Walked alone at _____ months.

Toilet trained: ❑ day ❑ night ❑ both

Physical development has been: ❑ rapid ❑ normal ❑ slow

Coordination is: ❑ good ❑ clumsy

Feeding difficulty ❑ none ❑ yes; describe: _____

Speech and Language

As an infant, child was responsive (laughed, smiled appropriately) ❑ Yes ❑ No

Age of first sounds _____ Example _____

first words _____ Example _____

phrases _____ Example _____

sentences _____ Example _____

Age at which you were first concerned about speech? _____

What caused your concern? _____

_____

Describe how your child communicates at the present time: _____

_____

Child can be understood by ❑ mother ❑ father ❑ other children ❑ relatives ❑ strangers

Is the child aware of his speech difficulty? ❑ Yes ❑ No ❑ N/A

How does he react? _____

_____

Is the child having difficulty in any other area at this time? _____

_____

SENSORY:

Does your child object to being touched or cuddled?	❑ Yes ❑ No
Does your child isolate self from other children?	❑ Yes ❑ No
Does your child seem overly sensitive to sound?	❑ Yes ❑ No
Does your child have difficulty following moving objects with his eyes?	❑ Yes ❑ No
Does your child appear sensitive to light?	❑ Yes ❑ No
Does your child explore by tasting?	❑ Yes ❑ No
Does your child dislike foods of a certain texture?	❑ Yes ❑ No
Does your child seem fearful in space (e.g., going up & down stairs, teeter-totter)	❑ Yes ❑ No
Does your child often bump into things/fall down?	❑ Yes ❑ No
Does your child prefer fast moving spinning rides?	❑ Yes ❑ No
Does your child seem weaker/stronger than normal?	❑ Yes ❑ No
Does your child manipulate small objects easily?	❑ Yes ❑ No

PEDIATRIC REHABILITATION SERVICES
THERAPY CASE HISTORY

Child's Name: _____

Daily Behavior

How does your child get along with other children? _____

Does your child prefer to play alone? _____

Describe favorite toys and how your child likes to play? _____

_____

_____

Would this child separate easily for therapy? _____

_____

Any other comments: _____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Jupiter Medical Center
Consent for Treatment - General

CONSENT TO TREATMENT: The undersigned, as the patient, or as the guardian or representative of the patient, consents to such laboratory, diagnostic and treatment procedures/examinations considered reasonably necessary for the care and treatment of my condition during my admission for outpatient or inpatient care as rendered to the patient under the instructions of a licensed physician or other health care practitioner.

AGREEMENT TO PAY CHARGES: I hereby assign to the health care entity my right to payment for healthcare services and supplies I receive from the health care entity. I direct anyone paying or receiving money for services or supplies I receive, to pay the money to Jupiter Medical Center or their affiliates. I understand that the health care services I receive may not be covered or paid for, or may only be partially covered or paid for, by my healthcare insurance company or any other third party payer. In the event that the billed charges for the healthcare services I receive are not covered or paid for on my behalf, or are only partially covered or paid, I understand and agree that I am responsible for the payment of the billed charges, or the remaining balance of billed charges for an such service or, if the health care entity has a contractual payment arrangement with my insurance company or third party payer, I will be responsible for the payment of any co-payments, deductibles, and co-insurance for covered services and billed charges for any non-covered services. Any phone number I have provided may be used for the purpose of collecting payments in connection with any services provided by any Jupiter Medical Center provider or affiliate.

PATIENT INFORMATION DISCLOSURE FOR TREATMENT, OPERATIONS AND PAYMENT: The undersigned, as the patient or as the guardian or authorized representative of the patient, authorizes JMC to release any and all information regarding the hospital services and supplies, for the purpose of treatment, operations or payment to any payer or other entity or person deemed necessary by JMC. This includes authorization to release information pertaining to psychiatric and/or psychological care (but not psychotherapy notes), alcohol and/or substance abuse and serologic test results including HIV. JMC may also obtain prescription history from the patient's insurance company and healthcare providers for the purpose of treatment.

MEDICARE AND MEDICAID BENEFITS: I certify that the information given by me in applying for payment under Medicare is correct (including the answers given by me in response to the questions of the Medicare Secondary Payer (MSP) questionnaire), I request payment of authorized Medical benefits on my behalf for services furnished to me by or in Jupiter Medical Center, including physician services, I authorize any holder of medical and other information about me to release to Medicare and its agents my information needed to determine these benefits or benefits for related services.

RELEASE OF LIABILITY AND RESPONSIBILITY FOR PERSONAL VALUABLES: I understand that I am responsible for all articles and personal property (money, documents, radios, jewelry, dentures, eyeglasses, hearing aids, etc.) and/or clothing which I retain in my possession (on my person or in my room) and for any other articles and/or clothing which may be brought to me while I am a patient in JMC. I hereby release JMC, physician(s) and team members from any claim for loss, damage to or complete destruction of such property, which is not deposited with the hospital for safekeeping in the hospital safe.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that a copy of the " Notice of Privacy Practices" has been made available to me.

INDEPENDENT CONTRACTORS: I acknowledge that some physicians and other providers operating and practicing in this hospital are not agents or employees of the hospital. These include but are not limited to the following groups: Emergency Physicians, Anesthesiologists, Pathologists, Radiologists, Staff and/or Contract Providers. Physicians and other providers bill separately for their services and may or may not accept my insurance.

STUDENT HEALTH CARE PROVIDERS: I understand healthcare may be provided to me in the form of services rendered by a student health care provider such as a student nurse, respiratory therapist, and pharmacy intern or radiology technology student participating in my care. I understand that by signing this form I am consenting to the supervised care rendered by such health care providers.

DIAGNOSTIC PHOTOGRAPHY AUTHORIZATION: I authorize radiographic films, x-rays, mammograms and other diagnostic films including still, movie or television photography to be taken of me during my hospital stay and consent to the use of such films for medical, scientific or educational purposes.

WORKERS COMPENSATION: According to Florida Statute section 440.105(7): "Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in **s.817,234."**

TOBACCO FREE ENVIRONMENT: I understand that Jupiter Medical Center is a tobacco-free environment and that I may not use tobacco products including cigarettes, cigars, pipes, herbal tobacco products, and chewing tobacco on the hospital campus or at any facility owned, [eased or operated by Jupiter Medical Center. I understand the use of electronic cigarettes or vapor is not recognized by Jupiter Medical Center as a nicotine replacement therapy and their use is also prohibited,

ADVANCE DIRECTIVE QUESTIONS:

1. Do you have an Advance Directive? ___yes ___no ____Unable to respond
2. If yes, is it on file? ___yes ___no. If no, copy requested? ___yes ___no
3. If no Advance Directive, copy given? ___yes ___declined

ACKNOWLEDGEMENT

The undersigned certifies that he/she has read and understood the foregoing and agrees to its terms:

_____	_____
Signature of Patient or Legally Authorized Representative	Printed Name of Patient
_____	_____
Relationship to Patient if signing on Patient's Behalf	Reason Patient Unable to Sign
_____	_____am/pm
Witness	Date and Time

JUPITER MEDICAL CENTER
Jupiter, Florida 33458

MEDICATION RECONCILIATION REPORT
OB & OUTPATIENT AREAS

Patient Name: _____ Date: _____ Source of Information:

DOB: _____ [ ] Patient

Medication Allergies: [ ] Family member

_____ [ ] Other

_____

_____

[ ] NOT TAKING ANY MEDICATIONS [ ] PREGNANT [ ] BREASTFEEDING

Are you on any antibiotics in preparation for this procedure? [ ] No [ ] Yes, if so include on list below

LIST ALL MEDICATIONS YOU ARE TAKING, INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS

MEDICATION	*DOSE*	*ROUTE*	*FREQUENCY*	*COMMENTS*	*CONTINUE*	*DISCONTINUE*
NEW MEDICATION/CHANGES TO MEDICATIONS FOLLOWING THIS VISIT:						

_____ _____ _____

Admission RN Signature Date Time

_____ _____ _____

Discharge RN Signature Date Time

1MR

JUPITER MEDICAL CENTER
1701 Military Trail, Suite 160A
JUPITER, FLORIDA 33458

Authorization for Release of Patient-Identifiable Health Information

For additional information please go to: www.jupitermed.com
For assistance with this form, please contact HIM: 561-263-7417

Acct #: _____
MR#: _____

☐ Copy Photo ID ☐ Leave Telephone Messages

Patient Name:	Phone Number:
Date of Birth:	Last four digits of SS #:

The type of information to be used or disclosed is as follows (check the appropriate boxes):

☐ Medical Abstract (Commonly used for continuation of care)
☐ Labs
☐ Emergency Room Records
☐ History and Physical
☐ Radiology Reports
☐ Consultations
☐ Operative Reports
☐ ECG / Echo Reports
☐ Pathology/ Cytology Reports
☐ Discharge Summary
☐ Other _____

Dates of Treatment: _____

The type of information to be disclosed for the following purpose (check one box):
☐ Legal ☐ Insurance ☐ Self ☐ Continuation of Care

I authorize _____ to release health information to:
(name of person or facility which has information)

Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

Street Address, City, State, Zip Code

Phone #_____ Fax #_____

Copies of the record may be (check one box):
☐ Mailed ☐ Picked up by _____
☐ Faxed (only to other healthcare providers in urgent situations)

INFORMATIONAL BROCHURE GIVEN:
☐ Yes Given ☐ Not Given ☐ Patient Declined **Initials:** _____

I hereby authorize release of information in my medical record which may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), record relating to behavioral or mental health services, and treatment for alcohol and/or drug abuse. ***Initials*** _____

If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days (6 months for series labs only).

Copies of records that are released for your own personal use are subject to a reasonable fee per page.

Signature of Patient:_____ Date: _____
Signature of Patient Representative:_____ Date: _____
Relationship to Patient:_____ Date: _____
Witness:_____ Date: _____

SIGNATURE FOR PICKUP OF RECORDS: _____ **DATE:** _____

2ROI

Authorization for Release of Patient- Identifiable Health Information

I hereby authorize release of information in my medical record which may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I hereby authorize release of information in my medical record which may include information relating to behavioral or mental health services, and treatment for alcohol and / or drug abuse. Initials _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released due to response to this authorization or the authorization was obtained as a condition of obtaining insurance coverage. Unless otherwise revoked this authorization will expire on the following date, event, or condition

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months.

If these copies of records are for your own personal use there is a charge at the rate of $1.00 per page pursuant to Florida Statute, Chapter 395.

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Office of Jupiter Medical Center.