Oasis Rehabilitation Services Inc.
1900 W 68th St E306, Hialeah, FL 33014
Tel: 305-606-4836
Fax: 786-542-1977

Patient History & Intake
Occupational & Physical Therapy

Patient Information

Admission Date: _____

Patient Name:	**Age:**	**DOB: ___/___/____**
Social Security #:	**Gender**: ☐ M ☐ F	**Diagnosis:**
Parent/Caregiver's Name:		
Address:		
City:	**State:**	**Zip code:**
Home Phone:	**Work phone:**	**Cell phone:**
Father's Name:		
Home Phone:	**Work phone:**	**Cell phone:**
Email:		
Can we leave messages regarding appointments on your home and mobile phone(s)? ☐ **Y** ☐ **N**		

Insurance Information

Type of insurance: ☐ Medicaid ☐ CMS ☐ Early Steps ☐Private Insurance ☐Private Pay ☐ Waiver			
Medicaid ID:	**HMO:**		
Early Steps (Services Coordinator):	**Phone**:		
Private Insurance:			
Name on policy:	Policy #:	Patient ID #:	
Address:	City:	State:	Zip:
Phone #:	Contact:	Type of Coverage:	

Physician Information

Primary Care Physician:	
Name:	**Phone number:**
Office Location:	**Fax Number:**
Other Referring Physician (Neurologist, Orthopedic, etc.)	**Phone: number:**
Name:	**Fax Number:**
What concerns you have regarding your child:	

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BIRTH HISTORY			
A. Pregnancy	☐ Full Term	☐Premature __wks. Birth Weight: ___	Length: ___
B. Method of Delivery	☐C-section Birth	☐Vaginal	Reason for C-Section:
C. Any difficulty prior to birth? If yes, Explain: _____			
B. Any difficulty after birth (e.g., hospitalization procedures etc.) If yes explain: _____			
D. How long was your child in the hospital following his/her birth? _____ If longer than average,_____			

MEDICAL HISTORY			
Mark any of the following that apply to your child:			
☐ chronic illness	☐chronic infections	☐allergies	☐lung/bronchial issues
☐hospitalizations	☐sight problems	☐hearing problems	☐heart defect
☐sleeping problems	☐physical injuries	☐difficulty eating	☐diabetes
☐ear infections	☐seizures	☐measles	☐tuberculosis
☐meningitis	☐chicken pox	☐high fever	
☐mumps	☐whooping cough	☐other:	
Is your child taking any medications at this time? ☐ Yes ☐ No			

CURRENT MEDICATION			
Name	Dosage	Frequency	Reason for Medication

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DEVELOPMENTAL HISTORY	
Fill in the blanks to describe your child to the best of your ability.	
Sat at _____months/ years	Talked at _____ months / years
Stood at _____ months /years	Dressed at _____ months / years
Walked at _____ months/ years	Fed self at _____ months / years
Ran at _____ months/ years	Toilet trained at _____ months/ years
Crawled at _____ months / years	
Child's physical development has been: Fast_____ Normal _____ Slow____	
Please list any motor concerns you have (e.g., gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.) _____	

BEHAVIORAL STATUS				
Mark any of the fallowing that best describes the behavior of your child.				
☐ Easily Managed.	☐ Temper tantrum.	☐ Is easy going.	☐ Slow learner.	☐ Is aggressive.
☐ Is social and engaging.	☐ Nervous.	☐ Follows directions.	☐ Does well with change	☐ Understands safety.
☐Has no playmates.	☐Poor coping skills.	☐ Does not like crows.	☐ Has difficulty with transitions.	☐ Takes turn with peers.
☐ Good eye contact.	☐ Prefers to play alone.	☐Has difficulty listening.	☐ Destructive.	
☐ Shy.	☐ Poor eye contact.	☐ Unable to self-calm.	☐ Unusual fears.	

Please list other therapies your child is receiving:

Type of Therapy	Frequency	Location	Name of therapist	Therapist Phone #

ADDITIONAL COMMENTS

PATIENT/ GUARDIAN SIGNATURE:	Date:
PRINT PATIENT/GUARDIAN'S NAME FROM ABOVE:	GUARDIAN'S RELATIONSHIP TO THE PATIENT:

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PATIENT CONSENT FORM (HIPAA)

I understand that I have certain rights to privacy regarding me protect health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA).

_____ (Patient initials). **Notice of Privacy Practices**. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact Oasis Rehabilitation Services Inc. if I have a question or complaint. I understand that this information may be disclosed electronically by Oasis Rehabilitation Services Inc. and/or the Provider's business associates to the extent permitted by law. I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials). **Release of Information** I hereby permit to Oasis Rehabilitation Services Inc, and others health professionals involved on direct or indirect treatment of my child to release healthcare information for purposes of treatment, payment, or healthcare operations.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but Oasis Rehabilitation Services Inc, are not required to agree to these requested restrictions. However, if Oasis Rehabilitation Services Inc, is agree, then Oasis Rehabilitation Services Inc. is bound to comply with this restriction. I understand that I may contact Oasis Rehabilitation Services Inc, at any time to obtain copy of this notice.

Disclosures to Friends and/or Family Members - Also can be used for Emergency Contact **DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

1. Name:_____ Relationship:_____ Phone #:_____
2. Name:_____ Relationship:_____ Phone #:_____
3. Name:_____ Relationship:_____ Phone #:_____

Patient/Legal Guardian may revoke or modify this specific authorization and that revocation or modification must be in writing.

PATIENT/ GUARDIAN SIGNATURE:	Date:
PRINT PATIENT/GUARDIAN'S NAME FROM ABOVE:	GUARDIAN'S RELATIONSHIP TO THE PATIEN:

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Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Oasis Rehabilitation Inc **Patient initials _____**

I consent to receive text messages from Oasis Rehabilitation Inc at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

Patient Name _____Signature _____ Date: _____

Revocation

I hereby revoke my request for future communications via email and/or text.

- ____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
- ____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

Patient/ Representative Name:_____ Signature: _____ Date: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

PATIENT/ GUARDIAN SIGNATURE:	DATE:
PRINT PATIENT/GUARDIAN'S NAME FROM ABOVE:	GUARDIAN'S RELATIONSHIP TO THE PATIENT:

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Consent to treatment

I give permission to the therapist of Oasis Rehabilitation Services Inc, to provide therapy treatment and any other supplementary services that are deemed medically necessary or appropriate to my child. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment result from the therapy.

PATIENT/ GUARDIAN SIGNATURE:	Date:
PRINT PATIENT/GUARDIAN'S NAME FROM ABOVE:	GUARDIAN'S RELATIONSHIP TO THE PATIENT:

Financial Responsibility

I agree that the agency will not bill me for therapy that is not paid for by Medicaid, an insurance plan, another creditor, or a legal representative. I further understand that once my child or ward is evaluated or re-evaluated, the agency has already paid for that service. In the event that I, the legal guardian, or designated representative choose not to provide service to my child or ward with Oasis Rehabilitation, I will be required to pay for the service incurred for the evaluation or re-evaluation within 30 days. The agency also agrees to provide you with a copy of your child or ward's evaluation.

PATIENT/ GUARDIAN SIGNATURE:	DATE:
PRINT PATIENT/GUARDIAN'S NAME FROM ABOVE:	GUARDIAN'S RELATIONSHIP TO THE PATIENT: