Sparrow

Medical History Information Form

Please answer the questions as completely as possible. If you need help filling out this form, we would be happy to assist you.

Patient Name_____ Birth Date: _____ Today's Date: _____

What is the reason for your Child's Visit Today:

☐ Relief from Pain	☐ Improve Head Shape	☐ Improve Handwriting
☐ Manage Tone	☐ Improve Head Position	☐ Improve Fine Motor
☐ Strengthen Core	☐ Strengthen Muscles	☐ Address Behavior Needs
☐ Improve Gross Motor	☐ Improve Walking	☐ Improve Communication
☐ Improve Flexibility	☐ Address Sensory Needs	☐ Improve Feeding

☐ Other: _____

What would you like your child to accomplish in therapy?

Pain: Do you feel that your child experiences pain? (Does your child demonstrate any signs of pain during rest or with movement?) ☐ yes ☐ no

Location of pain: ☐ Head ☐ Neck ☐ Shoulder ☐ Back ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

☐ Other: _____

Rate the Pain (0=no pain, 10=worst pain) _____

Current Medications (Please list type, dose and purpose of medication): ☐ NA

Allergies: ☐ NA

Food		**Environmental**		**Medications**
☐ Eggs	☐ Shell Fish	☐ Animal	☐ Mold and Mildew	☐ Penicillin
☐ Dairy	☐ Strawberries	☐ Dust	☐ Cockroaches	☐ Sulfa
☐ Gluten	☐ Tree Nuts	☐ Smoke	☐ Dust Mites	☐ Insulin
☐ Fish	☐ Peanuts	☐ Latex	☐ Adhesive	☐ Iodine
☐ Soy	☐ Other:_____	☐ Seasonal	☐ Other:_____	☐ Other:_____

Precautions (Please list any restrictions your child has including medical, emotional, physical restrictions): ☐ None

☐ Weight bearing ☐ Isolation ☐ Diagnosis Specific ☐ Spinal Precautions ☐ Feeding ☐ Cardiac

☐ Physician Directed ☐ Other: _____

Explain Precautions:_____

Preferred Language: ☐ English ☐ American Sign Language ☐ Arabic ☐ Chinese **Interpreter Needed**: ☐ yes ☐ no

☐ Nepali ☐ Somali ☐ Spanish ☐ Mandarin ☐ Other:_____

Do you have any additional needs? ☐ Nutrition Counseling ☐ Cultural/Religious Counseling ☐ Support Groups ☐ None

Does patient have a completed Advanced Directive (Document concerning medical procedures at end of life)? ☐ No ☐ Yes

Are you ready and able to learn a home exercise program? ☐ Yes ☐ No

Would you prefer instructions: ☐ Verbally ☐ As Written Documentation ☐ Through Demonstration

Parent Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Rev: 01/15

SPARROW
PEDIATRIC REHAB
ATTENDANCE POLICY

- It is important that you attend all of your scheduled therapy sessions.
- Please give at least 24 hours notice if you must cancel.

Department phone number: (517) 364-5464

- It is your responsibility to call and cancel your appointment if you are unable to keep it.
- Please arrive on time for your appointments. If you are more than 10 minutes late, you might not be treated that day.
- 3 no show/no call appointments will result in discharge from therapy.
- Missed appointments should be rescheduled.
- 4 missed appointments, within a 3-month period, will result in discharge from therapy.
    - Rescheduled appointments are not considered as a cancellation as long as appointment is rescheduled within the business week of the original appointment.
    - If a patient is discharged due to attendance, the discharge is effective for a minimum of 3 months.

Illness

- Please do not bring child to therapy if showing symptoms of illness requiring the child be kept home from school/daycare.
- Please do not bring child to therapy if current symptoms of illness require the attention of a physician.

I acknowledge that:

A copy of the Sparrow Health System's Notice of Privacy Practices was made available to me at the location where I received health care services.

The *Notice of Privacy Practices* was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I know that I can ask for a copy of the *Notice of Privacy Practices* to take with me.

If I came in for health care services in an emergency treatment situation, I was able to view the *Notice of Privacy Practices* as soon as reasonably practicable after the emergency treatment situation.

_____
Printed name of patient or patient's representative

_____ _____ _____
Signature of patient or patient's representative Date Time

_____
Relationship to patient (if other than patient)

Complete only if patient or representative signs by use of a mark:

_____
Printed name of witness

_____ _____ _____
Signature of witness Date Time

_____
Printed name of witness

_____ _____ _____
Signature of patient or patient's representative Date Time

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

Sparrow has verified the identification of _____ (patient's representative name) by _____ _____ (type of verification, e.g., driver's license) and that in his/her capacity of _ _____(description of authority to act, e.g. legal guardian, patient designated personal representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

_____ _____ _____
Associate name and signature Date Time

TO BE COMPLETED BY SPARROW HEALTH SYSTEM

If an acknowledgment is not obtained, describe Sparrow Health System's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained.

_____

_____

_____

PATIENT NAME: _____ **DATE OF ADMISSION/SERVICE**_____

PATIENT IDENTIFIER (DATE OF BIRTH): _____

MEDICAL CONSENT

I voluntarily and knowingly request and consent to the inpatient/outpatient services which may include medical treatment, x-rays, blood tests, laboratory tests, and other diagnostic tests deemed appropriate by any physician(s) or other health care provider(s). I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of care, treatment or examination. In addition, I understand and agree that this consent for treatment will extend to the hospital should I necessitate an admission to the hospital during or following my outpatient procedure.

I understand and consent to testing for HIV (Human Immunodeficiency Virus – AIDS), hepatitis, and/or other blood borne agents posing occupational risk may be performed on me if a health care professional, or first responder (police, firefighter, paramedic, etc.) sustains an exposure to my blood or other bodily fluids. I understand that Michigan law permits this testing, and should such testing occur, I will not be billed for it.

I consent to the disposal of any specimens or tissue taken from my body during my hospitalization and/or treatment. I further consent that any form of visual media of me may be taken during the course of treatment and may be used for teaching purposes. I further consent to the presence of and treatment by medical residents who are physicians in training at Sparrow Hospital.

I understand that these consents include the use of information that may be related to drug or alcohol abuse, psychiatric care, HIV testing, AIDS (Acquired Immune Deficiency Syndrome), HIV infection or ARC (AIDS Related Complex) and may include social worker/client communications and psychologist/client communications.

INITIAL HERE _____

Date_____Time_____

FINANCIAL CONSENT

Financial Agreement: I understand that Sparrow Hospital and those health care providers (including physicians) who are under contract with Sparrow Hospital or who otherwise provide services to patients of Sparrow Hospital ("Health Care Providers") submit claims to insurance carriers as a courtesy to patients. I understand that I am responsible for the balance owed to Sparrow Hospital or Health Care Providers after Sparrow Hospital and/or Health Care Providers have billed my insurance carrier(s). I understand that the physician services I received (including attending and consulting physicians, surgeons, anesthesiologists, radiologists and pathologists) are usually hired separately and that both Sparrow Hospital and any attending and consulting providers may bill me separately. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any insurance carrier, unless prohibited by law or contract. In addition, unless other arrangements are made in advance, I agree to pay my account in full after I receive services and to pay any legal fees and interest at the legal rate, which results due to my not paying the balance. I understand that neither Sparrow Hospital nor Health Care Providers accept liability for failure to meet any pre-certification required by my insurance carrier, and I agree to pay for all services if pre-certification is denied by my insurance carrier. I consent to Sparrow Hospital's use and disclosure of my health information to any person or organization that is legally or contractually responsible for payment of my bills for the services I received. I also consent to Sparrow Hospital's disclosure of my health information to attending and consulting providers for billing purposes.

Assignment of Benefits: I hereby assign to Sparrow Hospital and Health Care Providers all of my insurance and managed care benefit due to me for services rendered to me by Sparrow Hospital and/or Health Care Providers. I authorize my insurance company and/or my managed care company to make payment directly to Sparrow Hospital and/or Health Care Providers.

PATIENT NAME: _____ **DATE OF ADMISSION/SERVICE**_____

PATIENT IDENTIFIER (DATE OF BIRTH): _____

Physician Billings: I understand that the physician services I received (including attending and consulting physicians, surgeons, anesthesiologists, radiologists and pathologists) are usually hired separately and that I may be billed separately by both Sparrow Hospital and any attending and consulting providers. I consent to Sparrow Hospital disclosure of my health information only to attending and consulting providers for billing purposes.

INITIAL HERE _____

VALUABLES RELEASE

Date_____Time_____

I understand and agree that Sparrow is not responsible for my valuables, personal belongings or any property kept in my possession or in my room while I am a patient at Sparrow Hospital. I declare that I do not need and therefore, decline valuable safekeeping services as provided by Sparrow Security Dept. I hereby release Sparrow from any responsibility for loss of or damage to any personal property or money kept in my possession or in my room while I am a patient.

Date_____Time_____ **INITIAL HERE _____**

I understand that any aspect of this Consent and Release Form that I do not understand can be explained to me in further detail by asking my physician(s) or health care provider or their associates. I certify that this Consent and Release Form has been explained to me or that I have read it or have had it read to me, and that I understand its contents.

_____
Printed name of patient or patient's representative

_____ _____
Signature of patient or patient's representative Date

Time_____

Complete the following ONLY if patient or representative signs by use of a mark:

_____
Printed name of witness

_____ _____
Signature of witness Date

Time_____

_____
Print name of witness

_____ _____
Signature of witness Date

Time_____

If the above signature is that of a patient's representative, Sparrow must complete the following

Sparrow has verified the identification of _____(patient's representative name) by_____ (type of verification, e.g., driver's license) and that in his/her capacity of _____ (description of authority to act, e.g. legal guardian, patient designated personal representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by: _____ _____
Associate Name & Signature Date

Time_____

Patient Information / Responsibilities

SCHEDULING

We will work with you and your physician to optimize the outcome of your therapy. It is important that you attend all of your scheduled therapy sessions.

- It is your responsibility to call and cancel your appointment if you are unable to keep it.
- Please give at least 24 hours notice if you must cancel.
- It is your responsibility to arrive for your appointments on time. If you are more than 10 minutes late, you may not be seen for your scheduled appointment.
- By signing below you are acknowledging receipt of the Sparrow Pediatric Rehabilitation Attendance Policy. Please keep this information for future reference.

INSURANCE

Please Note: The following information is being provided to help you have a better understanding of your insurance requirements.

- Patients are responsible for knowing their benefits and assuring that authorization, if required, is obtained.
- Some insurance companies restrict payment for certain diagnoses. You may wish to talk with your therapist regarding your child's specific diagnosis and check with your insurance company for any restrictions.
- Information received from your insurance company is not a guarantee of payment. Determination of insurance payment can only be made after your insurance company has reviewed our billing and documentation. You will be responsible for paying any amount due that your insurance does not cover.
- Some insurance companies will authorize therapy only on a limited basis. If there are limits to the benefit amount or number of visits allowed, please be sure to monitor this information so that you remain within your policy limitations.
- Contact your insurance company directly for an explanation of your specific benefits.
- **You must notify us immediately to discuss any changes in your insurance while you are undergoing therapy.**

We look forward to serving you. If you need to cancel an appointment or have any questions regarding your treatment, please contact our department at 517.364.5464.

_____

Patient Name

_____ _____

Parent/Guardian Signature Date

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Yellow-Patient White - Chart