Welcome to Amerimed Therapy Services! We are honored you have chosen us to serve you. Our goal is to meet your needs in the most caring and efficient way. We are excited to work with you and learn more about your family. There are a few things would like for you to know about us.

Location:
3322 Greystone Way- Suite B
Valdosta, GA 31605
***We also provide services in other locations. Let us know if you child attends a local preschool or daycare. We will let you know if we offer treatment on site.*

Office hours:

Monday – Thursday
8:30 a.m. to 5:30 p.m.

Our Team:

We have a dynamic team of speech and occupational therapist who love working with children with a broad range of abilities, diagnoses, and developmental levels. Our therapist work together as a team to provide the best treatment and services. Together, we will ensure all of your child's needs are met.

Therapy Sessions:

Our therapist have plan a 30 minute therapy session for your child. A couple of minutes at the end of the session will be assigned to update you on their progress and a summary of the treatment. Please arrive and pick up your child at the assigned time. This will allow us to provide the best service to all our patients.

Cancellations:

For your child to make the most progress in the quickest amount of time, it is important to attend therapy on a consistent basis. If an excessive amount of appointments are missed in a one-month period, your therapist will attempt to contact you regarding this situation. However if the situation cannot be resolved, your child will be discharged at the discretion of your therapist.

No shows/Missed Appointments:

If three consecutive scheduled appointments are missed without being cancelled, your therapist will attempt to contact you regarding these missed appointments. Your child will be discharged under your therapist's discretion if she is unable to contact you.

Patients will be charged a Cancellation or No-Show fee of $30 if we are not notified at least 3 hours before your scheduled appointment. Your insurance company will not cover this fee.

Patient Information

Patients Name: ___________________________________ I prefer to be called: __________________

Date of Birth: _____/_____/______ Sex: Male or Female (circle) Home Phone: (______)_______________

Address: __________________________________City:_______________State:_______Zip________

Father's Name: ____ DOB: ___/___/_______

Father's Home #: (_____)_____________ Cell#: (_____)_____________ Work #:(_____)_____________

Mother's Name: ____DOB: ___/___/______

Mother's Home #: (_____)_____________ Cell#: (_____)_____________ Work#: (_____)_____________

Person to contact in case of emergency: ___________________________Phone: (_____)____________

The best time to contact me is: _____________ ☐ A.M. ☐ P.M. on my ☐ Home ☐ Work ☐ Cell phone

Check Appropriate Box for patient: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School________________________ City/State__________________ ☐ FT ☐ PT

Does your child receive therapy services in the School System? Yes or No (**If yes, please fill out page 3)**

Has your child received speech or occupational therapy services at another clinic? Yes or No **(If yes, please fill out page 4)**

Primary Physician's Name: ______________________________ Phone: (______)_______________

Referring Physician's Name: _____________________________ Phone: (______)_______________

Whom may we thank for referring you? ____

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: ____ Phone: (_____)________________

Address: __________________________________City:_______________State:_______Zip________

SSN#______________________________Employer____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. If for any reason any portion is not paid by my insurance, I agree to make arrangements for prompt payments of the account. I have read all the above information and have completed the above answers truthfully and correctly. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

____ ________________________

Signature of Patient (Parent or Guardian if a Minor) Date

Insurance Information

****Please provide a copy of your medical insurance card(s) to the receptionist.****

Patients Name: ____ Date of Birth: ____/____/______

Check Appropriate Box or Boxes: ☐ Private Insurance ☐ Medicaid ☐ PeachCare for Kids
☐ PeachState ☐ Wellcare ☐ Amerigroup ☐ Tricare ☐ Private Pay ☐ Other

Primary Insurance

Name of Policy Holder: ____ DOB ___/___/______

Relationship to Patient __________________ SSN#:___________________________

Name of Employer:__________________________ Work Phone: (____)_________________

Insurance Company____

ID#____ Group #_________________________

Ins Co Address: ________________________________City:______________State:_____Zip________

Ins Co. Phone: _________________________________

DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING SECONDARY INSURANCE INFORMATION.....

Secondary Insurance

Name of Policy Holder: ____ DOB ___/___/______

Relationship to Patient ___________________ SSN#:___________________________

Name of Employer:__________________________ Work Phone: (____)_________________

Insurance Company____

ID#____ Group #_________________________

Ins Co Address: ________________________________City:______________State:_____Zip________

Ins Co. Phone: _________________________________

Pediatric Case History Form

General Information

Child's Name:________________________________ Date of Birth:________________

Address:____________________________________ Phone:_____________________

City:__________________ Zip Code:_____________

Child lives with: ___Parents ___Grandparents ___Foster home ___other (_____________)

Mother's Name:____________________________________ Age:____________

Mother's Occupation:________________________________ Phone:_______________

Father's Name:_____________________________________ Age:____________

Father's Occupation:_________________________________ Phone:_______________

Reason for Referral:____

____

Medical Diagnosis: ____

Pediatrician:__________________________________Phone:_____________________

Brother and Sisters (include names and ages):

____

____

What is the primary language spoken by child?________________________________

Are there other languages spoken at home?________ If so, what language?__________

Has your child received a hearing screening and/or hearing evaluation?_____________

If yes, please list results and doctor/facility that performed the test:_______________

____

Please describe the child's speech-language problem.

____

____

____

____

How does the child communicate his/her wants and needs? (gestures, single words, short phrases, sentences, ect?)

____

____

When was the problem first notices? By whom?

____

____

Is the child aware of the problem? If yes, how does he/she feel about it?

____

____

Is your child currently receiving any other therapy services in the community? If so, what type and where?

____

____

Are there any other speech, language, or hearing problems in your family? Are there any other sensory or fine motor problems in your family? If so, please describe.

____

____

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medication, etc.)?

____

____

Length of pregnancy:________________________ Length of labor:______________________

General condition :___________________________Birth weight:_________________________

Postnatal: ☐ Required Oxygen ☐ Surgery ☐ Sucking or Swallowing problems

Medical History

Please check the following as they apply to your child:

☐ Low birth weight	☐ Hearing Loss	☐ 3 or More Ear Infections
☐ Allergies (Sinusitis, food, etc)	☐ Seizure Disorder	☐ Syndrome: ____________
☐ Surgeries	☐ Cleft Lip	☐ Cleft Palate
☐ Asthma	☐ Diabetes	☐ Cerebral Palsy
☐ Gastric Reflux	☐ Tonsillitis	☐ Hyperactivity/ADD

☐ Other significant illnesses not listed above:____

____

Has the child had any surgeries? If yes, what type and when?

____

____

Describe any major accidents or hospitalizations.

____

____

Is the child taking any medications? If yes, please list below.

____

____

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl:____________________ Use single words (no, mama):________________________

Sit:________________________ Combine words (me go, daddy up):________________

Stand:____________________ Name simple objects (dog, ball, hat):_______________

Walk:_____________________ Ask simple questions (Where mama?):______________

Feed self:_________________ Engage in conversation:_____________________________

Dress self:_________________

Use toilet:_________________

Is the child uncoordinated or clumsy?____

Does the child lose their balance or fall easily?____________________________________

Does the child display hand preference?_____________ ☐ Left ☐ Right

Are there or has there ever been any feeding problems (problems with sucking, swallowing, drooling excessively, chewing, using utensils, drinking from or holding cup, picky eater)? If yes, please describe.

____

____

____

Are there things that seem to upset the child (loud noises, textures, sounds, etc.)?

____

____

How does the child interact with others (friendly, shy, aggressive, uncooperative)?

____

____

Indicate with a check mark any/all areas of difficulty:

☐ Zippers/Buttons
☐ Hopping/jumping
☐ Lifting head while on stomach
☐ Rolling over
☐ Sitting Alone
☐ Creeping on hands and knees
☐ Copying Shapes
☐ Pulling to sit/stand
☐ Walking backwards
☐ Dressing

☐ Handwriting
☐ Accepting weight into legs
☐ Lacing/tying shoes
☐ Bringing hands together at midline
☐ Standing at furniture
☐ Standing Alone
☐ Bearing weight on arms
☐ Transferring objects from hand

☐ Cutting on a line around a shape
☐ Throwing ball overhand
☐ Walking/Running/ Jumping
☐ Walking up/down steps
☐ Building tower with blocks
☐ Balancing/hopping on one foot

Person completing form:____

Relationship to client:____

Signature:____________________________ Date:______________________